



110TH CONGRESS
2D SESSION

H. R. 6212

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 2008

Ms. JACKSON-LEE of Texas (for herself, Mr. TOWNS, Mr. DAVIS of Illinois, and Mr. RODRIGUEZ) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) **SHORT TITLE.**—This Act may be cited as the
 3 “Medicare Efficiency and Development of Improvement of
 4 Care and Services Act (MEDICS Act) of 2008”.

5 (b) **TABLE OF CONTENTS.**—The table of contents of
 6 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE

Subtitle A—Beneficiary Improvements

PART I—PREVENTION, MENTAL HEALTH, AND MARKETING

Sec. 101. Improvements to coverage of preventive services.

Sec. 102. Elimination of discriminatory copayment rates for Medicare out-patient psychiatric services.

Sec. 103. Prohibitions and limitations on certain sales and marketing activities under Medicare Advantage plans and prescription drug plans.

Sec. 104. Improvements to the Medigap program.

PART II—LOW-INCOME PROGRAMS

Sec. 111. Extension of qualifying individual (QI) program.

Sec. 112. Application of full LIS subsidy assets test under Medicare Savings Program.

Sec. 113. Eliminating barriers to enrollment.

Sec. 114. Elimination of Medicare part D late enrollment penalties paid by subsidy eligible individuals.

Sec. 115. Eliminating application of estate recovery.

Sec. 116. Exemptions from income and resources for determination of eligibility for low-income subsidy.

Sec. 117. Judicial review of decisions of the Commissioner of Social Security under the Medicare part D low-income subsidy program.

Sec. 118. Translation of model form.

Sec. 119. Medicare enrollment assistance.

Subtitle B—Provisions Relating to Part A

Sec. 121. Expansion and extension of the Medicare Rural Hospital Flexibility Program.

Sec. 122. Rebasing for sole community hospitals.

Sec. 123. Demonstration project on community health integration models in certain rural counties.

Sec. 124. Extension of the reclassification of certain hospitals.

Sec. 125. Revocation of unique deeming authority of the Joint Commission.

Subtitle C—Provisions Relating to Part B

PART I—PHYSICIANS’ SERVICES

- Sec. 131. Physician payment, efficiency, and quality improvements.
- Sec. 132. Incentives for electronic prescribing.
- Sec. 133. Expanding access to primary care services.
- Sec. 134. Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule.
- Sec. 135. Imaging provisions.
- Sec. 136. Extension of treatment of certain physician pathology services under Medicare.
- Sec. 137. Accommodation of physicians ordered to active duty in the Armed Services.
- Sec. 138. Adjustment for Medicare mental health services.
- Sec. 139. Improvements for Medicare anesthesia teaching programs.

PART II—OTHER PAYMENT AND COVERAGE IMPROVEMENTS

- Sec. 141. Extension of exceptions process for Medicare therapy caps.
- Sec. 142. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.
- Sec. 143. Speech-language pathology services.
- Sec. 144. Payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions.
- Sec. 145. Revision of payment for power-driven wheelchairs.
- Sec. 146. Clinical laboratory tests.
- Sec. 147. Improved access to ambulance services.
- Sec. 148. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals.
- Sec. 149. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.
- Sec. 150. Adding certain entities as originating sites for payment of telehealth services.
- Sec. 151. MedPAC study and report on improving chronic care demonstration programs.
- Sec. 152. Increase of FQHC payment limits.
- Sec. 153. Kidney disease education and awareness provisions.
- Sec. 154. Renal dialysis provisions.

Subtitle D—Provisions Relating to Part C

- Sec. 161. Phase-out of indirect medical education (IME).
- Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans.
- Sec. 163. Revisions to quality improvement programs.
- Sec. 164. Revisions relating to specialized Medicare Advantage plans for special needs individuals.
- Sec. 165. Limitation on out-of-pocket costs for dual eligibles and qualified medicare beneficiaries enrolled in a specialized Medicare Advantage plan for special needs individuals.
- Sec. 166. Adjustment to the Medicare Advantage stabilization fund.
- Sec. 167. Access to Medicare reasonable cost contract plans.
- Sec. 168. MedPAC study and report on quality measures.
- Sec. 169. MedPAC study and report on Medicare Advantage payments.

Subtitle E—Provisions Relating to Part D

PART I—IMPROVING PHARMACY ACCESS

- Sec. 171. Prompt payment by prescription drug plans and MA–PD plans under part D.
- Sec. 172. Submission of claims by pharmacies located in or contracting with long-term care facilities.
- Sec. 173. Regular update of prescription drug pricing standard.

PART II—OTHER PROVISIONS

- Sec. 175. Inclusion of barbiturates and benzodiazepines as covered part D drugs.
- Sec. 176. Formulary requirements with respect to certain categories or classes of drugs.

Subtitle F—Other Provisions

- Sec. 181. Use of part D data.
- Sec. 182. Revision of definition of medically accepted indication for drugs.
- Sec. 183. Contract with a consensus-based entity regarding performance measurement.
- Sec. 184. Cost-sharing for clinical trials.
- Sec. 185. Addressing health care disparities.
- Sec. 186. Demonstration to improve care to previously uninsured.
- Sec. 187. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
- Sec. 188. Medicare Improvement Funding.

TITLE II—MEDICAID

- Sec. 201. Extension of transitional medical assistance (TMA).
- Sec. 202. Medicaid DSH extension.
- Sec. 203. Pharmacy reimbursement under Medicaid.
- Sec. 204. Review of administrative claim determinations.

TITLE III—MISCELLANEOUS

- Sec. 301. Extension of TANF supplemental grants.
- Sec. 302. 70 percent federal matching for foster care and adoption assistance for the District of Columbia.
- Sec. 303. Extension of Special Diabetes Grant Programs.
- Sec. 304. IOM reports on best practices for conducting systematic reviews of clinical effectiveness research and for developing clinical protocols.
- Sec. 305. Increasing number of primary care physicians.

TITLE I—MEDICARE
Subtitle A—Beneficiary
Improvements

PART I—PREVENTION, MENTAL HEALTH, AND
MARKETING

SEC. 101. IMPROVEMENTS TO COVERAGE OF PREVENTIVE
SERVICES.

(a) COVERAGE OF ADDITIONAL PREVENTIVE SERV-
ICES.—

(1) COVERAGE.—Section 1861 of the Social Se-
curity Act (42 U.S.C. 1395x), as amended by section
114 of the Medicare, Medicaid, and SCHIP Exten-
sion Act of 2007 (Public Law 110–173), is amend-
ed—

(A) in subsection (s)(2)—

(i) in subparagraph (Z), by striking
“and” after the semicolon at the end;

(ii) in subparagraph (AA), by adding
“and” after the semicolon at the end; and

(iii) by adding at the end the fol-
lowing new subparagraph:

“(BB) additional preventive services (described
in subsection (ddd)(1));”; and

(B) by adding at the end the following new
subsection:

1 “Additional Preventive Services

2 “(ddd)(1) The term ‘additional preventive services’
3 means services not otherwise described in this title that
4 identify medical conditions or risk factors and that the
5 Secretary determines are—

6 “(A) reasonable and necessary for the preven-
7 tion or early detection of an illness or disability;

8 “(B) recommended with a grade of A or B by
9 the United States Preventive Services Task Force;
10 and

11 “(C) appropriate for individuals entitled to ben-
12 efits under part A or enrolled under part B.

13 “(2) In making determinations under paragraph (1)
14 regarding the coverage of a new service, the Secretary
15 shall use the process for making national coverage deter-
16 minations (as defined in section 1869(f)(1)(B)) under this
17 title. As part of the use of such process, the Secretary
18 may conduct an assessment of the relation between pre-
19 dicted outcomes and the expenditures for such service and
20 may take into account the results of such assessment in
21 making such determination.”.

22 (2) PAYMENT AND COINSURANCE FOR ADDI-
23 TIONAL PREVENTIVE SERVICES.—Section 1833(a)(1)
24 of the Social Security Act (42 U.S.C. 1395l(a)(1))
25 is amended—

1 (A) by striking “and” before “(V)”; and
2 (B) by inserting before the semicolon at
3 the end the following: “, and (W) with respect
4 to additional preventive services (as defined in
5 section 1861(ddd)(1)), the amount paid shall be
6 (i) in the case of such services which are clinical
7 diagnostic laboratory tests, the amount deter-
8 mined under subparagraph (D), and (ii) in the
9 case of all other such services, 80 percent of the
10 lesser of the actual charge for the service or the
11 amount determined under a fee schedule estab-
12 lished by the Secretary for purposes of this sub-
13 paragraph”.

14 (3) CONFORMING AMENDMENT REGARDING
15 COVERAGE.—Section 1862(a)(1)(A) of the Social Se-
16 curity Act (42 U.S.C. 1395y(a)(1)(A)) is amended
17 by inserting “or additional preventive services (as
18 described in section 1861(ddd)(1))” after “suc-
19 ceeding subparagraph”.

20 (4) RULE OF CONSTRUCTION.—Nothing in the
21 provisions of, or amendments made by, this sub-
22 section shall be construed to provide coverage under
23 title XVIII of the Social Security Act of items and
24 services for the treatment of a medical condition
25 that is not otherwise covered under such title.

1 (b) REVISIONS TO INITIAL PREVENTIVE PHYSICAL
2 EXAMINATION.—

3 (1) IN GENERAL.—Section 1861(ww) of the So-
4 cial Security Act (42 U.S.C. 1395x(ww)) is amend-
5 ed—

6 (A) in paragraph (1)—

7 (i) by inserting “body mass index,”
8 after “weight”;

9 (ii) by striking “, and an electro-
10 cardiogram”; and

11 (iii) by inserting “and end-of-life plan-
12 ning (as defined in paragraph (3)) upon
13 the agreement with the individual” after
14 “paragraph (2)”;

15 (B) in paragraph (2), by adding at the end
16 the following new subparagraphs:

17 “(M) An electrocardiogram.

18 “(N) Additional preventive services (as defined
19 in subsection (ddd)(1)).”; and

20 (C) by adding at the end the following new
21 paragraph:

22 “(3) For purposes of paragraph (1), the term ‘end-
23 of-life planning’ means verbal or written information re-
24 garding—

1 “(A) an individual’s ability to prepare an ad-
2 vance directive in the case that an injury or illness
3 causes the individual to be unable to make health
4 care decisions; and

5 “(B) whether or not the physician is willing to
6 follow the individual’s wishes as expressed in an ad-
7 vance directive.”.

8 (2) WAIVER OF APPLICATION OF DEDUCT-
9 IBLE.—The first sentence of section 1833(b) of the
10 Social Security Act (42 U.S.C. 1395l(b)) is amend-
11 ed—

12 (A) by striking “and” before “(8)”; and

13 (B) by inserting “, and (9) such deductible
14 shall not apply with respect to an initial preven-
15 tive physical examination (as defined in section
16 1861(w))” before the period at the end.

17 (3) EXTENSION OF ELIGIBILITY PERIOD FROM
18 SIX MONTHS TO ONE YEAR.—Section 1862(a)(1)(K)
19 of the Social Security Act (42 U.S.C.
20 1395y(a)(1)(K)) is amended by striking “6 months”
21 and inserting “1 year”.

22 (4) TECHNICAL CORRECTION.—Section
23 1862(a)(1)(K) of the Social Security Act (42 U.S.C.
24 1395y(a)(1)(K)) is amended by striking “not later”
25 and inserting “more”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2009.

4 **SEC. 102. ELIMINATION OF DISCRIMINATORY COPAYMENT**
5 **RATES FOR MEDICARE OUTPATIENT PSY-**
6 **CHIATRIC SERVICES.**

7 Section 1833(c) of the Social Security Act (42 U.S.C.
8 1395l(c)) is amended to read as follows:

9 “(c)(1) Notwithstanding any other provision of this
10 part, with respect to expenses incurred in a calendar year
11 in connection with the treatment of mental, psycho-
12 neurotic, and personality disorders of an individual who
13 is not an inpatient of a hospital at the time such expenses
14 are incurred, there shall be considered as incurred ex-
15 penses for purposes of subsections (a) and (b)—

16 “(A) for expenses incurred in years prior to
17 2010, only 62½ percent of such expenses;

18 “(B) for expenses incurred in 2010 or 2011,
19 only 68¾ percent of such expenses;

20 “(C) for expenses incurred in 2012, only 75
21 percent of such expenses;

22 “(D) for expenses incurred in 2013, only 81¼
23 percent of such expenses; and

24 “(E) for expenses incurred in 2014 or any sub-
25 sequent calendar year, 100 percent of such expenses.

1 “(2) For purposes of subparagraphs (A) through (D)
 2 of paragraph (1), the term ‘treatment’ does not include
 3 brief office visits (as defined by the Secretary) for the sole
 4 purpose of monitoring or changing drug prescriptions used
 5 in the treatment of such disorders or partial hospitaliza-
 6 tion services that are not directly provided by a physi-
 7 cian.”.

8 **SEC. 103. PROHIBITIONS AND LIMITATIONS ON CERTAIN**
 9 **SALES AND MARKETING ACTIVITIES UNDER**
 10 **MEDICARE ADVANTAGE PLANS AND PRE-**
 11 **SCRIPTION DRUG PLANS.**

12 (a) PROHIBITIONS.—

13 (1) MEDICARE ADVANTAGE PROGRAM.—

14 (A) IN GENERAL.—Section 1851 of the So-
 15 cial Security Act (42 U.S.C. 1395w-21) is
 16 amended—

17 (i) in subsection (h)(4)—

18 (I) in subparagraph (A)—

19 (aa) by striking “cash or
 20 other monetary rebates” and in-
 21 serting “, subject to subsection
 22 (j)(2)(C), cash, gifts, prizes, or
 23 other monetary rebates”; and

1 (bb) by striking “, and” at
2 the end and inserting a semi-
3 colon;

4 (II) in subparagraph (B), by
5 striking the period at the end and in-
6 serting a semicolon; and

7 (III) by adding at the end the
8 following new subparagraph:

9 “(C) shall not permit a Medicare Advan-
10 tage organization (or the agents, brokers, and
11 other third parties representing such organiza-
12 tion) to conduct the prohibited activities de-
13 scribed in subsection (j)(1); and”;

14 (ii) by adding at the end the following
15 new subsection:

16 “(j) PROHIBITED ACTIVITIES DESCRIBED AND LIM-
17 ITATIONS ON THE CONDUCT OF CERTAIN OTHER ACTIVI-
18 TIES.—

19 “(1) PROHIBITED ACTIVITIES DESCRIBED.—

20 The following prohibited activities are described in
21 this paragraph:

22 “(A) UNSOLICITED MEANS OF DIRECT
23 CONTACT.—Any unsolicited means of direct
24 contact of prospective enrollees, including solici-
25 ting door-to-door or any outbound tele-

1 marketing without the prospective enrollee initi-
2 ating contact.

3 “(B) CROSS-SELLING.—The sale of other
4 non-health related products (such as annuities
5 and life insurance) during any sales or mar-
6 keting activity or presentation conducted with
7 respect to a Medicare Advantage plan.

8 “(C) MEALS.—The provision of meals of
9 any sort, regardless of value, to prospective en-
10 rollees at promotional and sales activities.

11 “(D) SALES AND MARKETING IN HEALTH
12 CARE SETTINGS AND AT EDUCATIONAL
13 EVENTS.—Sales and marketing activities for
14 the enrollment of individuals in Medicare Ad-
15 vantage plans that are conducted—

16 “(i) in health care settings in areas
17 where health care is delivered to individ-
18 uals (such as physician offices and phar-
19 macies), except in the case where such ac-
20 tivities are conducted in common areas in
21 health care settings; and

22 “(ii) at educational events.”.

23 (2) MEDICARE PRESCRIPTION DRUG PRO-
24 GRAM.—Section 1860D–4 of the Social Security Act

1 (42 U.S.C. 1395w–104) is amended by adding at
2 the end the following new subsection:

3 “(l) REQUIREMENTS WITH RESPECT TO SALES AND
4 MARKETING ACTIVITIES.—The following provisions shall
5 apply to a PDP sponsor (and the agents, brokers, and
6 other third parties representing such sponsor) in the same
7 manner as such provisions apply to a Medicare Advantage
8 organization (and the agents, brokers, and other third par-
9 ties representing such organization):

10 “(1) The prohibition under section
11 1851(h)(4)(C) on conducting activities described in
12 section 1851(j)(1).”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to plan years begin-
15 ning on or after January 1, 2009.

16 (b) LIMITATIONS.—

17 (1) MEDICARE ADVANTAGE PROGRAM.—Section
18 1851 of the Social Security Act (42 U.S.C. 1395w–
19 21), as amended by subsection (a)(1), is amended—

20 (A) in subsection (h)(4), by adding at the
21 end the following new subparagraph:

22 “(D) shall only permit a Medicare Advan-
23 tage organization (and the agents, brokers, and
24 other third parties representing such organiza-
25 tion) to conduct the activities described in sub-

1 section (j)(2) in accordance with the limitations
2 established under such subsection.”; and

3 (B) in subsection (j), by adding at the end
4 the following new paragraph:

5 “(2) LIMITATIONS.—The Secretary shall estab-
6 lish limitations with respect to at least the following:

7 “(A) SCOPE OF MARKETING APPOINT-
8 MENTS.—The scope of any appointment with
9 respect to the marketing of a Medicare Advan-
10 tage plan. Such limitation shall require advance
11 agreement with a prospective enrollee on the
12 scope of the marketing appointment and docu-
13 mentation of such agreement by the Medicare
14 Advantage organization. In the case where the
15 marketing appointment is in person, such docu-
16 mentation shall be in writing.

17 “(B) CO-BRANDING.—The use of the name
18 or logo of a co-branded network provider on
19 Medicare Advantage plan membership and mar-
20 keting materials.

21 “(C) LIMITATION OF GIFTS TO NOMINAL
22 DOLLAR VALUE.—The offering of gifts and
23 other promotional items other than those that
24 are of nominal value (as determined by the Sec-

1 retary) to prospective enrollees at promotional
2 activities.

3 “(D) COMPENSATION.—The use of com-
4 pensation other than as provided under guide-
5 lines established by the Secretary. Such guide-
6 lines shall ensure that the use of compensation
7 creates incentives for agents and brokers to en-
8 roll individuals in the Medicare Advantage plan
9 that is intended to best meet their health care
10 needs.

11 “(E) REQUIRED TRAINING, ANNUAL RE-
12 TRAINING, AND TESTING OF AGENTS, BROKERS,
13 AND OTHER THIRD PARTIES.—The use by a
14 Medicare Advantage organization of any indi-
15 vidual as an agent, broker, or other third party
16 representing the organization that has not com-
17 pleted an initial training and testing program
18 and does not complete an annual retraining and
19 testing program.”.

20 (2) MEDICARE PRESCRIPTION DRUG PRO-
21 GRAM.—Section 1860D–4(l) of the Social Security
22 Act, as added by subsection (a)(2), is amended by
23 adding at the end the following new paragraph:

24 “(2) The requirement under section
25 1851(h)(4)(D) to conduct activities described in sec-

tion 1851(j)(2) in accordance with the limitations established under such subsection.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008).

(c) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—

(1) MEDICARE ADVANTAGE PROGRAM.—Section 1851(h) of the Social Security Act (42 U.S.C. 1395w–21(h)) is amended by adding at the end following new paragraph:

“(6) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).”.

(2) PRESCRIPTION DRUG PLANS.—Section 1860D–4(l) of the Social Security Act, as added by subsection (a)(2) and amended by subsection (b)(2), is amended by adding at the end the following new paragraph:

1 “(3) The inclusion of the plan type in the plan
2 name under section 1851(h)(6).”.

3 (d) STRENGTHENING THE ABILITY OF STATES TO
4 ACT IN COLLABORATION WITH THE SECRETARY TO AD-
5 DRESS FRAUDULENT OR INAPPROPRIATE MARKETING
6 PRACTICES.—

7 (1) MEDICARE ADVANTAGE PROGRAM.—Section
8 1851(h) of the Social Security Act (42 U.S.C.
9 1395w-21(h), as amended by subsection (c)(1), is
10 amended by adding at the end the following new
11 paragraph:

12 “(7) STRENGTHENING THE ABILITY OF STATES
13 TO ACT IN COLLABORATION WITH THE SECRETARY
14 TO ADDRESS FRAUDULENT OR INAPPROPRIATE MAR-
15 KETING PRACTICES.—

16 “(A) APPOINTMENT OF AGENTS AND BRO-
17 KERS.—Each Medicare Advantage organization
18 shall—

19 “(i) only use agents and brokers who
20 have been licensed under State law to sell
21 Medicare Advantage plans offered by the
22 Medicare Advantage organization;

23 “(ii) in the case where a State has a
24 State appointment law, abide by such law;
25 and

“(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

“(B) COMPLIANCE WITH STATE INFORMATION REQUESTS.—Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.”.

(2) PRESCRIPTION DRUG PLANS.—Section 1860D-4(l) of the Social Security Act, as amended by subsection (c)(2), is amended by adding at the end the following new paragraph:

“(4) The requirements regarding the appointment of agents and brokers and compliance with State information requests under subparagraphs (A) and (B), respectively, of section 1851(h)(7).”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2009.

1 **SEC. 104. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

2 (a) IMPLEMENTATION OF NAIC RECOMMENDA-
3 TIONS.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the
6 “Secretary”) shall provide for implementation of the
7 changes in the NAIC model law and regulations ap-
8 proved by the National Association of Insurance
9 Commissioners in its Model #651 (“Model Regula-
10 tion to Implement the NAIC Medicare Supplement
11 Insurance Minimum Standards Model Act”) on
12 March 11, 2007, as modified to reflect the changes
13 made under this Act and the Genetic Information
14 Nondiscrimination Act of 2008 (Public Law 110-
15 233).

16 (2) IMPLEMENTATION DATES.—

17 (A) IN GENERAL.—The modifications to
18 Model #651 required under paragraph (1) shall
19 be completed by the National Association of In-
20 surance Commissioners not later than October
21 31, 2008. Except as provided in subparagraph
22 (B), each State shall have 1 year from the date
23 the National Association of Insurance Commis-
24 sioners adopts the revised NAIC model law and
25 regulations (as changed by Model #651, as so
26 modified) to conform the regulatory program

1 established by the State to such revised NAIC
2 model law and regulations.

3 (B) EXTENSION OF EFFECTIVE DATE FOR
4 STATE LAW AMENDMENT.—In the case of a
5 State which the Secretary determines requires
6 State legislation in order to conform the regu-
7 latory program established by the State to such
8 revised NAIC model law and regulations, the
9 State shall not be regarded as failing to comply
10 with the requirements of this section solely on
11 the basis of its failure to meet such require-
12 ments before the first day of the first calendar
13 quarter beginning after the close of the first
14 regular session of the State legislature that be-
15 gins after the date of the enactment of this Act.
16 For purposes of the previous sentence, in the
17 case of a State that has a 2-year legislative ses-
18 sion, each year of the session is considered to
19 be a separate regular session of the State legis-
20 lature.

21 (C) TRANSITION DATES.—No carrier may
22 issue a new or revised medicare supplemental
23 policy or certificate under section 1882 of the
24 Social Security Act (42 U.S.C. 1395ss) that
25 meets the requirements of such revised NAIC

1 model law and regulations for coverage effective
2 prior to June 1, 2010. A carrier may continue
3 to offer or issue a medicare supplemental policy
4 under such section that meets the requirements
5 of the NAIC model law and regulations and
6 State law (as in effect prior to the adoption of
7 such revised NAIC model law and regulations)
8 prior to June 1, 2010. Nothing shall preclude
9 carriers from marketing new or revised medi-
10 care supplemental policies or certificates that
11 meet the requirements of such revised NAIC
12 model law and regulations on or after the date
13 on which the State conforms the regulatory pro-
14 gram established by the State to such revised
15 NAIC model law and regulations.

16 (b) REQUIRED OFFERING OF A RANGE OF POLI-
17 CIES.—Section 1882(o) of the Social Security Act (42
18 U.S.C. 1395s(o)) is amended by adding at the end the
19 following new paragraph:

20 “(4) In addition to the requirement under para-
21 graph (2), the issuer of the policy must make avail-
22 able to the individual at least Medicare supplemental
23 policies with benefit packages classified as ‘C’ or
24 ‘F’.”.

PART II—LOW-INCOME PROGRAMS

**SEC. 111. EXTENSION OF QUALIFYING INDIVIDUAL (QI)
PROGRAM.**

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “June 2008” and inserting “December 2009”.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of such Act (42 U.S.C. 1396u-3(g)) is amended—

(1) in paragraph (2)—

(A) by striking “and” at the end of subparagraph (H);

(B) in subparagraph (I)—

(i) by striking “June 30” and inserting “September 30”;

(ii) by striking “\$200,000,000” and inserting “\$300,000,000”; and

(iii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

“(J) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is \$100,000,000;

1 “(K) for the period that begins on January
2 1, 2009, and ends on September 30, 2009, the
3 total allocation amount is \$350,000,000; and

4 “(L) for the period that begins on October
5 1, 2009, and ends on December 31, 2009, the
6 total allocation amount is \$150,000,000.”; and

7 (2) in paragraph (3), in the matter preceding
8 subparagraph (A), by striking “or (H)” and insert-
9 ing “(H), (J), or (L)”.

10 **SEC. 112. APPLICATION OF FULL LIS SUBSIDY ASSETS TEST**
11 **UNDER MEDICARE SAVINGS PROGRAM.**

12 Section 1905(p)(1)(C) of such Act (42 U.S.C.
13 1396d(p)(1)(C)) is amended by inserting before the period
14 at the end the following: “or, effective beginning with Jan-
15 uary 1, 2010, whose resources (as so determined) do not
16 exceed the maximum resource level applied for the year
17 under subparagraph (D) of section 1860D–14(a)(3) (de-
18 termined without regard to the life insurance policy exclu-
19 sion provided under subparagraph (G) of such section) ap-
20 plicable to an individual or to the individual and the indi-
21 vidual’s spouse (as the case may be)”.

22 **SEC. 113. ELIMINATING BARRIERS TO ENROLLMENT.**

23 (a) SSA ASSISTANCE WITH MEDICARE SAVINGS
24 PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLI-
25 CATIONS.—Section 1144 of such Act (42 U.S.C. 1320b–

1 14) is amended by adding at the end the following new
2 subsection:

3 “(c) ASSISTANCE WITH MEDICARE SAVINGS PRO-
4 GRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICA-
5 TIONS.—

6 “(1) DISTRIBUTION OF APPLICATIONS AND IN-
7 FORMATION TO INDIVIDUALS WHO ARE POTEN-
8 Tially ELIGIBLE FOR LOW-INCOME SUBSIDY PRO-
9 GRAM.—For each individual who submits an applica-
10 tion for low-income subsidies under section 1860D-
11 14, requests an application for such subsidies, or is
12 otherwise identified as an individual who is poten-
13 tially eligible for such subsidies, the Commissioner
14 shall do the following:

15 “(A) Provide information describing the
16 low-income subsidy program under section
17 1860D-14 and the Medicare Savings Program
18 (as defined in paragraph (7)).

19 “(B) Provide an application for enrollment
20 under such low-income subsidy program (if not
21 already received by the Commissioner).

22 “(C) In accordance with paragraph (3),
23 transmit data from such an application for pur-
24 poses of initiating an application for benefits
25 under the Medicare Savings Program.

1 “(D) Provide information on how the indi-
2 vidual may obtain assistance in completing such
3 application and an application under the Medi-
4 care Savings Program, including information on
5 how the individual may contact the State health
6 insurance assistance program (SHIP).

7 “(E) Make the application described in
8 subparagraph (B) and the information de-
9 scribed in subparagraphs (A) and (D) available
10 at local offices of the Social Security Adminis-
11 tration.

12 “(2) TRAINING PERSONNEL IN EXPLAINING
13 BENEFIT PROGRAMS AND ASSISTING IN COMPLETING
14 LIS APPLICATION.—The Commissioner shall provide
15 training to those employees of the Social Security
16 Administration who are involved in receiving applica-
17 tions for benefits described in paragraph (1)(B) in
18 order that they may promote beneficiary under-
19 standing of the low-income subsidy program and the
20 Medicare Savings Program in order to increase par-
21 ticipation in these programs. Such employees shall
22 provide assistance in completing an application de-
23 scribed in paragraph (1)(B) upon request.

24 “(3) TRANSMITTAL OF DATA TO STATES.—Be-
25 ginning on January 1, 2010, with the consent of an

individual completing an application for benefits described in paragraph (1)(B), the Commissioner shall electronically transmit to the appropriate State Medicaid agency data from such application, as determined by the Commissioner, which transmittal shall initiate an application of the individual for benefits under the Medicare Savings Program. In order to ensure that such data transmittal provides effective assistance for purposes of State adjudication of applications for benefits under the Medicare Savings Program, the Commissioner shall consult with the Secretary, after the Secretary has consulted with the States, regarding the content, form, frequency, and manner in which data (on a uniform basis for all States) shall be transmitted under this subparagraph.

“(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection with outreach activities conducted by States in connection with the low-income subsidy program and the Medicare Savings Program.

“(5) REIMBURSEMENT OF SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE COSTS.—

1 “(A) INITIAL MEDICARE SAVINGS PRO-
2 GRAM COSTS; ADDITIONAL LOW-INCOME SUB-
3 SIDY COSTS.—

4 “(i) INITIAL MEDICARE SAVINGS PRO-
5 GRAM COSTS.—There are hereby appro-
6 priated to the Commissioner to carry out
7 this subsection, out of any funds in the
8 Treasury not otherwise appropriated,
9 \$21,100,000. The amount appropriated
10 under this clause shall be available on Octo-
11 ber 1, 2008, and shall remain available
12 until expended.

13 “(ii) ADDITIONAL AMOUNT FOR LOW-
14 INCOME SUBSIDY ACTIVITIES.—There are
15 hereby appropriated to the Commissioner,
16 out of any funds in the Treasury not oth-
17 erwise appropriated, \$24,800,000 for fiscal
18 year 2009 to carry out low-income subsidy
19 activities under this Act, to remain avail-
20 able until expended. Such funds shall be in
21 addition to the Social Security Administra-
22 tion’s Limitation on Administrative Ex-
23 penditure appropriations for such fiscal
24 year.

1 “(B) SUBSEQUENT FUNDING UNDER
2 AGREEMENTS.—

3 “(i) IN GENERAL.—Effective for fiscal
4 years beginning on or after October 1,
5 2010, the Commissioner and the Secretary
6 shall enter into an agreement which shall
7 provide funding to cover the administrative
8 costs of the Commissioner’s activities
9 under this subsection. Such agreement
10 shall—

11 “(I) provide funds to the Com-
12 missioner for the full cost of the So-
13 cial Security Administration’s work
14 related to the Medicare Savings Pro-
15 gram required under this section;

16 “(II) provide such funding quar-
17 terly in advance of the applicable
18 quarter based on estimating method-
19 ology agreed to by the Commissioner
20 and the Secretary; and

21 “(III) require an annual account-
22 ing and reconciliation of the actual
23 costs incurred and funds provided
24 under this subsection.

1 “(ii) APPROPRIATION.—There are
2 hereby appropriated to the Secretary solely
3 for the purpose of providing payments to
4 the Commissioner pursuant to an agree-
5 ment specified in clause (i) that is in ef-
6 fect, out of any funds in the Treasury not
7 otherwise appropriated, not more than
8 \$3,000,000 for fiscal year 2011 and each
9 fiscal year thereafter.

10 “(C) LIMITATION.—In no case shall funds
11 from the Social Security Administration’s Limi-
12 tation on Administrative Expenses be used to
13 carry out activities under this subsection. For
14 fiscal years beginning on or after October 1,
15 2010, no such activities shall be undertaken by
16 the Social Security Administration unless the
17 agreement specified in subparagraph (B) is in
18 effect and full funding has been provided to the
19 Commissioner as specified in such subpara-
20 graph.

21 “(6) GAO ANALYSIS AND REPORT.—

22 “(A) ANALYSIS.—The Comptroller General
23 of the United States shall prepare an analysis
24 of the impact of this subsection—

1 “(i) in increasing participation in the
2 Medicare Savings Program, and

3 “(ii) on States and the Social Security
4 Administration.

5 “(B) REPORT.—Not later than January 1,
6 2012, the Comptroller General shall submit to
7 Congress, the Commissioner, and the Secretary
8 a report on the analysis conducted under sub-
9 paragraph (A).

10 “(7) MEDICARE SAVINGS PROGRAM DEFINED.—
11 For purposes of this subsection, the term ‘Medicare
12 Savings Program’ means the program of medical as-
13 sistance for payment of the cost of medicare cost-
14 sharing under the Medicaid program pursuant to
15 sections 1902(a)(10)(E) and 1933.”.

16 (b) MEDICAID AGENCY CONSIDERATION OF DATA
17 TRANSMITTAL.—Section 1935(a) of such Act (42 U.S.C.
18 1396u-5(a)) is amended by adding at the end the fol-
19 lowing new paragraph:

20 “(4) CONSIDERATION OF DATA TRANSMITTED
21 BY THE SOCIAL SECURITY ADMINISTRATION FOR
22 PURPOSES OF MEDICARE SAVINGS PROGRAM.—The
23 State shall accept data transmitted under section
24 1144(c)(3) and act on such data in the same man-
25 ner and in accordance with the same deadlines as if

1 the data constituted an initiation of an application
 2 for benefits under the Medicare Savings Program
 3 (as defined for purposes of such section) that had
 4 been submitted directly by the applicant. The date
 5 of the individual's application for the low income
 6 subsidy program from which the data have been de-
 7 rived shall constitute the date of filing of such appli-
 8 cation for benefits under the Medicare Savings Pro-
 9 gram.”.

10 (c) EFFECTIVE DATE.—Except as otherwise pro-
 11 vided, the amendments made by this section shall take ef-
 12 fect on January 1, 2010.

13 **SEC. 114. ELIMINATION OF MEDICARE PART D LATE EN-**
 14 **ROLLMENT PENALTIES PAID BY SUBSIDY ELI-**
 15 **GIBLE INDIVIDUALS.**

16 (a) WAIVER OF LATE ENROLLMENT PENALTY.—

17 (1) IN GENERAL.—Section 1860D–13(b) of the
 18 Social Security Act (42 U.S.C. 1395w–113(b)) is
 19 amended by adding at the end the following new
 20 paragraph:

21 “(8) WAIVER OF PENALTY FOR SUBSIDY-ELIGI-
 22 BLE INDIVIDUALS.—In no case shall a part D eligi-
 23 ble individual who is determined to be a subsidy eli-
 24 gible individual (as defined in section 1860D–
 25 14(a)(3)) be subject to an increase in the monthly

beneficiary premium established under subsection (a).”.

(2) CONFORMING AMENDMENT.—Section 1860D–14(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(A)) is amended by striking “equal to” and all that follows through the period and inserting “equal to 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to subsidies for months beginning with January 2009.

SEC. 115. ELIMINATING APPLICATION OF ESTATE RECOVERY.

(a) IN GENERAL.—Section 1917(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is amended by inserting “(but not including medical assistance for medicare cost-sharing or for benefits described in section 1902(a)(10)(E))” before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as of January 1, 2010.

1 **SEC. 116. EXEMPTIONS FROM INCOME AND RESOURCES**
2 **FOR DETERMINATION OF ELIGIBILITY FOR**
3 **LOW-INCOME SUBSIDY.**

4 (a) IN GENERAL.—Section 1860D–14(a)(3) of the
5 Social Security Act (42 U.S.C. 1395w–114(a)(3)) is
6 amended—

7 (1) in subparagraph (C)(i), by inserting “and
8 except that support and maintenance furnished in
9 kind shall not be counted as income” after “section
10 1902(r)(2)”;

11 (2) in subparagraph (D), in the matter before
12 clause (i), by inserting “subject to the life insurance
13 policy exclusion provided under subparagraph (G)”
14 before “)”;

15 (3) in subparagraph (E)(i), in the matter before
16 subclause (I), by inserting “subject to the life insur-
17 ance policy exclusion provided under subparagraph
18 (G)” before “)”;

19 (4) by adding at the end the following new sub-
20 paragraph:

21 “(G) LIFE INSURANCE POLICY EXCLU-
22 SION.—In determining the resources of an indi-
23 vidual (and the eligible spouse of the individual,
24 if any) under section 1613 for purposes of sub-
25 paragraphs (D) and (E) no part of the value of

any life insurance policy shall be taken into account.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on January 1, 2010, and shall apply to determinations of eligibility for months beginning with January 2010.

SEC. 117. JUDICIAL REVIEW OF DECISIONS OF THE COMMISSIONER OF SOCIAL SECURITY UNDER THE MEDICARE PART D LOW-INCOME SUBSIDY PROGRAM.

(a) **IN GENERAL.**—Section 1860D–14(a)(3)(B)(iv) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)(iv)) is amended—

(1) in subclause (I), by striking “and” at the end;

(2) in subclause (II), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new subclause:

“(III) judicial review of the final decision of the Commissioner made after a hearing shall be available to the same extent, and with the same limitations, as provided in subsections (g) and (h) of section 205.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall take effect as if included in the enact-
3 ment of section 101 of the Medicare Prescription Drug,
4 Improvement, and Modernization Act of 2003.

5 **SEC. 118. TRANSLATION OF MODEL FORM.**

6 (a) IN GENERAL.—Section 1905(p)(5)(A) of the So-
7 cial Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended
8 by adding at the end the following: “The Secretary shall
9 provide for the translation of such application form into
10 at least the 10 languages (other than English) that are
11 most often used by individuals applying for hospital insur-
12 ance benefits under section 226 or 226A and shall make
13 the translated forms available to the States and to the
14 Commissioner of Social Security.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall take effect on January 1, 2010.

17 **SEC. 119. MEDICARE ENROLLMENT ASSISTANCE.**

18 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-
19 SURANCE ASSISTANCE PROGRAMS.—

20 (1) GRANTS.—

21 (A) IN GENERAL.—The Secretary of
22 Health and Human Services (in this section re-
23 ferred to as the “Secretary”) shall use amounts
24 made available under subparagraph (B) to
25 make grants to States for State health insur-

1 ance assistance programs receiving assistance
2 under section 4360 of the Omnibus Budget
3 Reconciliation Act of 1990.

4 (B) FUNDING.—For purposes of making
5 grants under this subsection, the Secretary
6 shall provide for the transfer, from the Federal
7 Hospital Insurance Trust Fund under section
8 1817 of the Social Security Act (42 U.S.C.
9 1395i) and the Federal Supplementary Medical
10 Insurance Trust Fund under section 1841 of
11 such Act (42 U.S.C. 1395t), in the same pro-
12 portion as the Secretary determines under sec-
13 tion 1853(f) of such Act (42 U.S.C. 1395w-
14 23(f)), of \$7,500,000 to the Centers for Medi-
15 care & Medicaid Services Program Management
16 Account for fiscal year 2009, to remain avail-
17 able until expended.

18 (2) AMOUNT OF GRANTS.—The amount of a
19 grant to a State under this subsection from the total
20 amount made available under paragraph (1) shall be
21 equal to the sum of the amount allocated to the
22 State under paragraph (3)(A) and the amount allo-
23 cated to the State under subparagraph (3)(B).

24 (3) ALLOCATION TO STATES.—

1 (A) ALLOCATION BASED ON PERCENTAGE
2 OF LOW-INCOME BENEFICIARIES.—The amount
3 allocated to a State under this subparagraph
4 from $\frac{2}{3}$ of the total amount made available
5 under paragraph (1) shall be based on the num-
6 ber of individuals who meet the requirement
7 under subsection (a)(3)(A)(ii) of section
8 1860D-14 of the Social Security Act (42
9 U.S.C. 1395w-114) but who have not enrolled
10 to receive a subsidy under such section 1860D-
11 14 relative to the total number of individuals
12 who meet the requirement under such sub-
13 section (a)(3)(A)(ii) in each State, as estimated
14 by the Secretary.

15 (B) ALLOCATION BASED ON PERCENTAGE
16 OF RURAL BENEFICIARIES.—The amount allo-
17 cated to a State under this subparagraph from
18 $\frac{1}{3}$ of the total amount made available under
19 paragraph (1) shall be based on the number of
20 part D eligible individuals (as defined in section
21 1860D-1(a)(3)(A) of such Act (42 U.S.C.
22 1395w-101(a)(3)(A))) residing in a rural area
23 relative to the total number of such individuals
24 in each State, as estimated by the Secretary.

(4) PORTION OF GRANT BASED ON PERCENT-
AGE OF LOW-INCOME BENEFICIARIES TO BE USED
TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY
BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE
FOR THE MEDICARE SAVINGS PROGRAM.—Each
grant awarded under this subsection with respect to
amounts allocated under paragraph (3)(A) shall be
used to provide outreach to individuals who may be
subsidy eligible individuals (as defined in section
1860D–14(a)(3)(A) of the Social Security Act (42
U.S.C. 1395w–114(a)(3)(A)) or eligible for the
Medicare Savings Program (as defined in subsection
(e)).

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
AGING.—

(1) GRANTS.—

(A) IN GENERAL.—The Secretary, acting
through the Assistant Secretary for Aging, shall
make grants to States for area agencies on
aging (as defined in section 102 of the Older
Americans Act of 1965 (42 U.S.C. 3002)).

(B) FUNDING.—For purposes of making
grants under this subsection, the Secretary
shall provide for the transfer, from the Federal
Hospital Insurance Trust Fund under section

1 1817 of the Social Security Act (42 U.S.C.
2 1395i) and the Federal Supplementary Medical
3 Insurance Trust Fund under section 1841 of
4 such Act (42 U.S.C. 1395t), in the same pro-
5 portion as the Secretary determines under sec-
6 tion 1853(f) of such Act (42 U.S.C. 1395w-
7 23(f)), of \$7,500,000 to the Administration on
8 Aging for fiscal year 2009, to remain available
9 until expended.

10 (2) AMOUNT OF GRANT AND ALLOCATION TO
11 STATES BASED ON PERCENTAGE OF LOW-INCOME
12 AND RURAL BENEFICIARIES.—The amount of a
13 grant to a State under this subsection from the total
14 amount made available under paragraph (1) shall be
15 determined in the same manner as the amount of a
16 grant to a State under subsection (a), from the total
17 amount made available under paragraph (1) of such
18 subsection, is determined under paragraph (2) and
19 subparagraphs (A) and (B) of paragraph (3) of such
20 subsection.

21 (3) REQUIRED USE OF FUNDS.—

22 (A) ALL FUNDS.—Subject to subparagraph
23 (B), each grant awarded under this subsection
24 shall be used to provide outreach to eligible
25 Medicare beneficiaries regarding the benefits

1 available under title XVIII of the Social Secu-
2 rity Act.

3 (B) OUTREACH TO INDIVIDUALS WHO MAY
4 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGI-
5 BLE FOR THE MEDICARE SAVINGS PROGRAM.—

6 Subsection (a)(4) shall apply to each grant
7 awarded under this subsection in the same
8 manner as it applies to a grant under sub-
9 section (a).

10 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
11 ABILITY RESOURCE CENTERS.—

12 (1) GRANTS.—

13 (A) IN GENERAL.—The Secretary shall
14 make grants to Aging and Disability Resource
15 Centers under the Aging and Disability Re-
16 source Center grant program that are estab-
17 lished centers under such program on the date
18 of the enactment of this Act.

19 (B) FUNDING.—For purposes of making
20 grants under this subsection, the Secretary
21 shall provide for the transfer, from the Federal
22 Hospital Insurance Trust Fund under section
23 1817 of the Social Security Act (42 U.S.C.
24 1395i) and the Federal Supplementary Medical
25 Insurance Trust Fund under section 1841 of

1 such Act (42 U.S.C. 1395t), in the same pro-
2 portion as the Secretary determines under sec-
3 tion 1853(f) of such Act (42 U.S.C. 1395w-
4 23(f)), of \$5,000,000 to the Administration on
5 Aging for fiscal year 2009, to remain available
6 until expended.

7 (2) REQUIRED USE OF FUNDS.—Each grant
8 awarded under this subsection shall be used to pro-
9 vide outreach to individuals regarding the benefits
10 available under the Medicare prescription drug ben-
11 efit under part D of title XVIII of the Social Secu-
12 rity Act and under the Medicare Savings Program.

13 (d) COORDINATION OF EFFORTS TO INFORM OLDER
14 AMERICANS ABOUT BENEFITS AVAILABLE UNDER FED-
15 ERAL AND STATE PROGRAMS.—

16 (1) IN GENERAL.—The Secretary, acting
17 through the Assistant Secretary for Aging, in co-
18 operation with related Federal agency partners, shall
19 make a grant to, or enter into a contract with, a
20 qualified, experienced entity under which the entity
21 shall—

22 (A) maintain and update web-based deci-
23 sion support tools, and integrated, person-cen-
24 tered systems, designed to inform older individ-
25 uals (as defined in section 102 of the Older

Americans Act of 1965 (42 U.S.C. 3002))
about the full range of benefits for which the
individuals may be eligible under Federal and
State programs;

(B) utilize cost-effective strategies to find
older individuals with the greatest economic
need (as defined in such section 102) and in-
form the individuals of the programs;

(C) develop and maintain an information
clearinghouse on best practices and the most
cost-effective methods for finding older individ-
uals with greatest economic need and informing
the individuals of the programs; and

(D) provide, in collaboration with related
Federal agency partners administering the Fed-
eral programs, training and technical assistance
on the most effective outreach, screening, and
follow-up strategies for the Federal and State
programs.

(2) FUNDING.—For purposes of making a
grant or entering into a contract under paragraph
(1), the Secretary shall provide for the transfer,
from the Federal Hospital Insurance Trust Fund
under section 1817 of the Social Security Act (42
U.S.C. 1395i) and the Federal Supplementary Med-

1 ical Insurance Trust Fund under section 1841 of
2 such Act (42 U.S.C. 1395t), in the same proportion
3 as the Secretary determines under section 1853(f) of
4 such Act (42 U.S.C. 1395w–23(f)), of \$5,000,000 to
5 the Administration on Aging for fiscal year 2009, to
6 remain available until expended.

(e) MEDICARE SAVINGS PROGRAM DEFINED.—For purposes of this section, the term “Medicare Savings Program” means the program of medical assistance for payment of the cost of medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933 of the Social Security Act (42 U.S.C. 1396a(a)(10)(E), 1396u-3).

14 **Subtitle B—Provisions Relating to**
15 **Part A**

16 SEC. 121. EXPANSION AND EXTENSION OF THE MEDICARE
17 RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) IN GENERAL.—Section 1820(g) of the Social Security Act (42 U.S.C. 1395i-4(g)) is amended by adding at the end the following new paragraph:

21 “(6) PROVIDING MENTAL HEALTH SERVICES
22 AND OTHER HEALTH SERVICES TO VETERANS AND
23 OTHER RESIDENTS OF RURAL AREAS.—

24 “(A) GRANTS TO STATES.—The Secretary
25 may award grants to States that have sub-

mitted applications in accordance with subparagraph (B) for increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas (as defined for purposes of section 1886(d) and including areas that are rural census tracts, as defined by the Administrator of the Health Resources and Services Administration), including for the provision of crisis intervention services and the detection of post-traumatic stress disorder, traumatic brain injury, and other signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas.

“(B) APPLICATION.—

“(i) IN GENERAL.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the

1 assurances described in subparagraphs
2 (A)(ii) and (A)(iii) of subsection (b)(1).

3 “(ii) CONSIDERATION OF REGIONAL
4 APPROACHES, NETWORKS, OR TECH-
5 NOLOGY.—The Secretary may, as appro-
6 priate in awarding grants to States under
7 subparagraph (A), consider whether the
8 application submitted by a State under
9 this subparagraph includes 1 or more pro-
10 posals that utilize regional approaches,
11 networks, health information technology,
12 telehealth, or telemedicine to deliver serv-
13 ices described in subparagraph (A) to indi-
14 viduals described in that subparagraph.
15 For purposes of this clause, a network
16 may, as the Secretary determines appro-
17 priate, include federally qualified health
18 centers, rural health clinics, home health
19 agencies, community mental health clinics
20 and other providers of mental health serv-
21 ices, pharmacists, local government, and
22 other providers deemed necessary to meet
23 the needs of veterans.

24 “(iii) COORDINATION AT LOCAL
25 LEVEL.—The Secretary shall require, as

1 appropriate, a State to demonstrate con-
2 sultation with the hospital association of
3 such State, rural hospitals located in such
4 State, providers of mental health services,
5 or other appropriate stakeholders for the
6 provision of services under a grant award-
7 ed under this paragraph.

8 “(iv) SPECIAL CONSIDERATION OF
9 CERTAIN APPLICATIONS.—In awarding
10 grants to States under subparagraph (A),
11 the Secretary shall give special consider-
12 ation to applications submitted by States
13 in which veterans make up a high percent-
14 age (as determined by the Secretary) of
15 the total population of the State. Such
16 consideration shall be given without regard
17 to the number of veterans of Operation
18 Iraqi Freedom and Operation Enduring
19 Freedom living in the areas in which men-
20 tal health services and other health care
21 services would be delivered under the appli-
22 cation.

23 “(C) COORDINATION WITH VA.—The Sec-
24 retary shall, as appropriate, consult with the
25 Director of the Office of Rural Health of the

1 Department of Veterans Affairs in awarding
2 and administering grants to States under sub-
3 paragraph (A).

4 “(D) USE OF FUNDS.—A State awarded a
5 grant under this paragraph may, as appro-
6 priate, use the funds to reimburse providers of
7 services described in subparagraph (A) to indi-
8 viduals described in that subparagraph.

9 “(E) LIMITATION ON USE OF GRANT
10 FUNDS FOR ADMINISTRATIVE EXPENSES.—A
11 State awarded a grant under this paragraph
12 may not expend more than 15 percent of the
13 amount of the grant for administrative ex-
14 penses.

15 “(F) INDEPENDENT EVALUATION AND
16 FINAL REPORT.—The Secretary shall provide
17 for an independent evaluation of the grants
18 awarded under subparagraph (A). Not later
19 than 1 year after the date on which the last
20 grant is awarded to a State under such sub-
21 paragraph, the Secretary shall submit a report
22 to Congress on such evaluation. Such report
23 shall include an assessment of the impact of
24 such grants on increasing the delivery of mental
25 health services and other health services to vet-

erans of the United States Armed Forces living in rural areas (as so defined and including such areas that are rural census tracts), with particular emphasis on the impact of such grants on the delivery of such services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, and to other individuals living in such rural areas.”.

(b) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Section 1820(g)(5) of the Social Security Act (42 U.S.C. 1395i-4(g)(5)) is amended—

(1) by striking “beginning with fiscal year 2005” and inserting “for each of fiscal years 2005 through 2008”; and

(2) by inserting “and, of the total amount appropriated for grants under paragraphs (1), (2), and (6) for a fiscal year (beginning with fiscal year 2009)” after “2005)”.

(c) EXTENSION OF AUTHORIZATION FOR FLEX GRANTS.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i-4(j)) is amended—

(1) by striking “and for” and inserting “for”; and

(2) by inserting “, for making grants to all States under paragraphs (1) and (2) of subsection

1 (g), \$55,000,000 in each of fiscal years 2009 and
2 2010, and for making grants to all States under
3 paragraph (6) of subsection (g), \$50,000,000 in
4 each of fiscal years 2009 and 2010, to remain avail-
5 able until expended” before the period at the end.

6 (d) MEDICARE RURAL HOSPITAL FLEXIBILITY PRO-
7 GRAM.—Section 1820(g)(1) of the Social Security Act (42
8 U.S.C. 1395i-4(g)(1)) is amended—

9 (1) in subparagraph (B), by striking “and” at
10 the end;

11 (2) in subparagraph (C), by striking the period
12 at the end and inserting “; and”; and

13 (3) by adding at the end the following new sub-
14 paragraph:

15 “(D) providing support for critical access
16 hospitals for quality improvement, quality re-
17 porting, performance improvements, and
18 benchmarking.”.

19 (e) ASSISTANCE TO SMALL CRITICAL ACCESS HOS-
20 PITALS TRANSITIONING TO SKILLED NURSING FACILI-
21 TIES AND ASSISTED LIVING FACILITIES.—Section
22 1820(g) of the Social Security Act (42 U.S.C. 1395i-
23 4(g)), as amended by subsection (a), is amended by adding
24 at the end the following new paragraph:

1 “(7) CRITICAL ACCESS HOSPITALS
2 TRANSITIONING TO SKILLED NURSING FACILITIES
3 AND ASSISTED LIVING FACILITIES.—

4 “(A) GRANTS.—The Secretary may award
5 grants to eligible critical access hospitals that
6 have submitted applications in accordance with
7 subparagraph (B) for assisting such hospitals
8 in the transition to skilled nursing facilities and
9 assisted living facilities.

10 “(B) APPLICATION.—An applicable critical
11 access hospital seeking a grant under this para-
12 graph shall submit an application to the Sec-
13 retary on or before such date and in such form
14 and manner as the Secretary specifies.

15 “(C) ADDITIONAL REQUIREMENTS.—The
16 Secretary may not award a grant under this
17 paragraph to an eligible critical access hospital
18 unless—

19 “(i) local organizations or the State in
20 which the hospital is located provides
21 matching funds; and

22 “(ii) the hospital provides assurances
23 that it will surrender critical access hos-
24 pital status under this title within 180
25 days of receiving the grant.

1 “(D) AMOUNT OF GRANT.—A grant to an
2 eligible critical access hospital under this para-
3 graph may not exceed \$1,000,000.

4 “(E) FUNDING.—There are appropriated
5 from the Federal Hospital Insurance Trust
6 Fund under section 1817 for making grants
7 under this paragraph, \$5,000,000 for fiscal
8 year 2008.

9 “(F) ELIGIBLE CRITICAL ACCESS HOS-
10 PITAL DEFINED.—For purposes of this para-
11 graph, the term ‘eligible critical access hospital’
12 means a critical access hospital that has an av-
13 erage daily acute census of less than 0.5 and an
14 average daily swing bed census of greater than
15 10.0.’’.

16 **SEC. 122. REBASING FOR SOLE COMMUNITY HOSPITALS.**

17 (a) REBASING PERMITTED.—Section 1886(b)(3) of
18 the Social Security Act (42 U.S.C. 1395ww(b)(3)) is
19 amended by adding at the end the following new subpara-
20 graph:

21 “(L)(i) For cost reporting periods beginning on or
22 after January 1, 2009, in the case of a sole community
23 hospital there shall be substituted for the amount other-
24 wise determined under subsection (d)(5)(D)(i) of this sec-
25 tion, if such substitution results in a greater amount of

1 payment under this section for the hospital, the subpara-
2 graph (L) rebased target amount.

3 “(ii) For purposes of this subparagraph, the term
4 ‘subparagraph (L) rebased target amount’ has the mean-
5 ing given the term ‘target amount’ in subparagraph (C),
6 except that—

7 “(I) there shall be substituted for the base cost
8 reporting period the 12-month cost reporting period
9 beginning during fiscal year 2006;

10 “(II) any reference in subparagraph (C)(i) to
11 the ‘first cost reporting period’ described in such
12 subparagraph is deemed a reference to the first cost
13 reporting period beginning on or after January 1,
14 2009; and

15 “(III) the applicable percentage increase shall
16 only be applied under subparagraph (C)(iv) for dis-
17 charges occurring on or after January 1, 2009.”.

18 (b) CONFORMING AMENDMENTS.—Section
19 1886(b)(3) of the Social Security Act (42 U.S.C.
20 1395ww(b)(3)) is amended—

21 (1) in subparagraph (C), in the matter pre-
22 ceding clause (i), by striking “subparagraph (I)”
23 and inserting “subparagraphs (I) and (L)”; and

1 (2) in subparagraph (I)(i), in the matter pre-
2 ceding subclause (I), by striking “For” and inserting
3 “Subject to subparagraph (L), for”.

4 **SEC. 123. DEMONSTRATION PROJECT ON COMMUNITY**
5 **HEALTH INTEGRATION MODELS IN CERTAIN**
6 **RURAL COUNTIES.**

7 (a) **IN GENERAL.**—The Secretary shall establish a
8 demonstration project to allow eligible entities to develop
9 and test new models for the delivery of health care services
10 in eligible counties for the purpose of improving access to,
11 and better integrating the delivery of, acute care, extended
12 care, and other essential health care services to Medicare
13 beneficiaries.

14 (b) **PURPOSE.**—The purpose of the demonstration
15 project under this section is to—

16 (1) explore ways to increase access to, and im-
17 prove the adequacy of, payments for acute care, ex-
18 tended care, and other essential health care services
19 provided under the Medicare and Medicaid programs
20 in eligible counties; and

21 (2) evaluate regulatory challenges facing such
22 providers and the communities they serve.

23 (c) **REQUIREMENTS.**—The following requirements
24 shall apply under the demonstration project:

1 (1) Health care providers in eligible counties se-
2 lected to participate in the demonstration project
3 under subsection (d)(3) shall (when determined ap-
4 propriate by the Secretary), instead of the payment
5 rates otherwise applicable under the Medicare pro-
6 gram, be reimbursed at a rate that covers at least
7 the reasonable costs of the provider in furnishing
8 acute care, extended care, and other essential health
9 care services to Medicare beneficiaries.

10 (2) Methods to coordinate the survey and cer-
11 tification process under the Medicare program and
12 the Medicaid program across all health service cat-
13 egories included in the demonstration project shall
14 be tested with the goal of assuring quality and safe-
15 ty while reducing administrative burdens, as appro-
16 priate, related to completing such survey and certifi-
17 cation process.

18 (3) Health care providers in eligible counties se-
19 lected to participate in the demonstration project
20 under subsection (d)(3) and the Secretary shall work
21 with the State to explore ways to revise reimburse-
22 ment policies under the Medicaid program to im-
23 prove access to the range of health care services
24 available in such eligible counties.

1 (4) The Secretary shall identify regulatory re-
2 quirements that may be revised appropriately to im-
3 prove access to care in eligible counties.

4 (5) Other essential health care services nec-
5 essary to ensure access to the range of health care
6 services in eligible counties selected to participate in
7 the demonstration project under subsection (d)(3)
8 shall be identified. Ways to ensure adequate funding
9 for such services shall also be explored.

10 (d) APPLICATION PROCESS.—

11 (1) ELIGIBILITY.—

12 (A) IN GENERAL.—Eligibility to partici-
13 pate in the demonstration project under this
14 section shall be limited to eligible entities.

15 (B) ELIGIBLE ENTITY DEFINED.—In this
16 section, the term “eligible entity” means an en-
17 tity that—

18 (i) is a Rural Hospital Flexibility Pro-
19 gram grantee under section 1820(g) of the
20 Social Security Act (42 U.S.C. 1395i-
21 4(g)); and

22 (ii) is located in a State in which at
23 least 65 percent of the counties in the
24 State are counties that have 6 or less resi-
25 dents per square mile.

1 (2) APPLICATION.—

2 (A) IN GENERAL.—An eligible entity seek-
3 ing to participate in the demonstration project
4 under this section shall submit an application to
5 the Secretary at such time, in such manner,
6 and containing such information as the Sec-
7 retary may require.

8 (B) LIMITATION.—The Secretary shall se-
9 lect eligible entities located in not more than 4
10 States to participate in the demonstration
11 project under this section.

12 (3) SELECTION OF ELIGIBLE COUNTIES.—An
13 eligible entity selected by the Secretary to partici-
14 pate in the demonstration project under this section
15 shall select not more than 6 eligible counties in the
16 State in which the entity is located in which to con-
17 duct the demonstration project.

18 (4) ELIGIBLE COUNTY DEFINED.—In this sec-
19 tion, the term “eligible county” means a county that
20 meets the following requirements:

21 (A) The county has 6 or less residents per
22 square mile.

23 (B) As of the date of the enactment of this
24 Act, a facility designated as a critical access

1 hospital which meets the following requirements
2 was located in the county:

3 (i) As of the date of the enactment of
4 this Act, the critical access hospital fur-
5 nished 1 or more of the following:

6 (I) Home health services.

7 (II) Hospice care.

8 (III) Rural health clinic services.

9 (ii) As of the date of the enactment of
10 this Act, the critical access hospital has an
11 average daily inpatient census of 5 or less.

12 (C) As of the date of the enactment of this
13 Act, skilled nursing facility services were avail-
14 able in the county in—

15 (i) a critical access hospital using
16 swing beds; or

17 (ii) a local nursing home.

18 (e) ADMINISTRATION.—

19 (1) IN GENERAL.—The demonstration project
20 under this section shall be administered jointly by
21 the Administrator of the Office of Rural Health Pol-
22 icy of the Health Resources and Services Adminis-
23 tration and the Administrator of the Centers for
24 Medicare & Medicaid Services, in accordance with
25 paragraphs (2) and (3).

1 (2) HRSA DUTIES.—In administering the dem-
2 onstration project under this section, the Adminis-
3 trator of the Office of Rural Health Policy of the
4 Health Resources and Services Administration
5 shall—

6 (A) award grants to the eligible entities se-
7 lected to participate in the demonstration
8 project; and

9 (B) work with such entities to provide
10 technical assistance related to the requirements
11 under the project.

12 (3) CMS DUTIES.—In administering the dem-
13 onstration project under this section, the Adminis-
14 trator of the Centers for Medicare & Medicaid Serv-
15 ices shall determine which provisions of titles XVIII
16 and XIX of the Social Security Act (42 U.S.C. 1395
17 et seq.; 1396 et seq.) the Secretary should waive
18 under the waiver authority under subsection (i) that
19 are relevant to the development of alternative reim-
20 bursement methodologies, which may include, as ap-
21 propriate, covering at least the reasonable costs of
22 the provider in furnishing acute care, extended care,
23 and other essential health care services to Medicare
24 beneficiaries and coordinating the survey and certifi-
25 cation process under the Medicare and Medicaid pro-

1 grams, as appropriate, across all service categories
2 included in the demonstration project.

3 (f) DURATION.—

4 (1) IN GENERAL.—The demonstration project
5 under this section shall be conducted for a 3-year
6 period beginning on October 1, 2009.

7 (2) BEGINNING DATE OF DEMONSTRATION
8 PROJECT.—The demonstration project under this
9 section shall be considered to have begun in a State
10 on the date on which the eligible counties selected to
11 participate in the demonstration project under sub-
12 section (d)(3) begin operations in accordance with
13 the requirements under the demonstration project.

14 (g) FUNDING.—

15 (1) CMS.—

16 (A) IN GENERAL.—The Secretary shall
17 provide for the transfer, in appropriate part
18 from the Federal Hospital Insurance Trust
19 Fund established under section 1817 of the So-
20 cial Security Act (42 U.S.C. 1395i) and the
21 Federal Supplementary Medical Insurance
22 Trust Fund established under section 1841 of
23 such Act (42 U.S.C. 1395t), of such sums as
24 are necessary for the costs to the Centers for
25 Medicare & Medicaid Services of carrying out

its duties under the demonstration project under this section.

(B) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration project under this section was not implemented.

(2) HRSA.—There are authorized to be appropriated to the Office of Rural Health Policy of the Health Resources and Services Administration \$800,000 for each of fiscal years 2010, 2011, and 2012 for the purpose of carrying out the duties of such Office under the demonstration project under this section, to remain available for the duration of the demonstration project.

(h) REPORT.—

(1) INTERIM REPORT.—Not later than the date that is 2 years after the date on which the demonstration project under this section is implemented, the Administrator of the Office of Rural Health Policy of the Health Resources and Services Administration, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall

1 submit a report to Congress on the status of the
2 demonstration project that includes initial rec-
3 ommendations on ways to improve access to, and the
4 availability of, health care services in eligible coun-
5 ties based on the findings of the demonstration
6 project.

7 (2) FINAL REPORT.—Not later than 1 year
8 after the completion of the demonstration project,
9 the Administrator of the Office of Rural Health Pol-
10 icy of the Health Resources and Services Adminis-
11 tration, in coordination with the Administrator of
12 the Centers for Medicare & Medicaid Services, shall
13 submit a report to Congress on such project, to-
14 gether with recommendations for such legislation
15 and administrative action as the Secretary deter-
16 mines appropriate.

17 (i) WAIVER AUTHORITY.—The Secretary may waive
18 such requirements of titles XVIII and XIX of the Social
19 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
20 may be necessary and appropriate for the purpose of car-
21 rying out the demonstration project under this section.

22 (j) DEFINITIONS.—In this section:

23 (1) EXTENDED CARE SERVICES.—The term
24 “extended care services” means the following:

25 (A) Home health services.

1 (B) Covered skilled nursing facility serv-
2 ices.

3 (C) Hospice care.

4 (2) COVERED SKILLED NURSING FACILITY
5 SERVICES.—The term “covered skilled nursing facil-
6 ity services” has the meaning given such term in
7 section 1888(e)(2)(A) of the Social Security Act (42
8 U.S.C. 1395yy(e)(2)(A)).

9 (3) CRITICAL ACCESS HOSPITAL.—The term
10 “critical access hospital” means a facility designated
11 as a critical access hospital under section 1820(c) of
12 such Act (42 U.S.C. 1395i–4(c)).

13 (4) HOME HEALTH SERVICES.—The term
14 “home health services” has the meaning given such
15 term in section 1861(m) of such Act (42 U.S.C.
16 1395x(m)).

17 (5) HOSPICE CARE.—The term “hospice care”
18 has the meaning given such term in section
19 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

20 (6) MEDICAID PROGRAM.—The term “Medicaid
21 program” means the program under title XIX of
22 such Act (42 U.S.C. 1396 et seq.).

23 (7) MEDICARE PROGRAM.—The term “Medicare
24 program” means the program under title XVIII of
25 such Act (42 U.S.C. 1395 et seq.).

1 (8) OTHER ESSENTIAL HEALTH CARE SERV-
 2 ICES.—The term “other essential health care serv-
 3 ices” means the following:

4 (A) Ambulance services (as described in
 5 section 1861(s)(7) of the Social Security Act
 6 (42 U.S.C. 1395x(s)(7))).

7 (B) Rural health clinic services.

8 (C) Public health services (as defined by
 9 the Secretary).

10 (D) Other health care services determined
 11 appropriate by the Secretary.

12 (9) RURAL HEALTH CLINIC SERVICES.—The
 13 term “rural health clinic services” has the meaning
 14 given such term in section 1861(aa)(1) of such Act
 15 (42 U.S.C. 1395x(aa)(1)).

16 (10) SECRETARY.—The term “Secretary”
 17 means the Secretary of Health and Human Services.

18 **SEC. 124. EXTENSION OF THE RECLASSIFICATION OF CER-**
 19 **TAIN HOSPITALS.**

20 (a) IN GENERAL.—Subsection (a) of section 106 of
 21 division B of the Tax Relief and Health Care Act of 2006
 22 (42 U.S.C. 1395 note), as amended by section 117 of the
 23 Medicare, Medicaid, and SCHIP Extension Act of 2007
 24 (Public Law 110–173), is amended by striking “Sep-
 25 tember 30, 2008” and inserting “September 30, 2009”.

1 (b) SPECIAL EXCEPTION RECLASSIFICATIONS.—Sec-
2 tion 117(a)(2) of the Medicare, Medicaid, and SCHIP Ex-
3 tension Act of 2007 (Public Law 110–173) is amended
4 by striking “September 30, 2008” and inserting “Sep-
5 tember 30, 2009”.

6 **SEC. 125. REVOCATION OF UNIQUE DEEMING AUTHORITY**
7 **OF THE JOINT COMMISSION.**

8 (a) REVOCATION.—Section 1865 of the Social Secu-
9 rity Act (42 U.S.C. 1395bb) is amended—

10 (1) by striking subsection (a); and

11 (2) by redesignating subsections (b), (c), (d),
12 and (e) as subsections (a), (b), (c), and (d), respec-
13 tively.

14 (b) CONFORMING AMENDMENTS.—(1) Section 1865
15 of the Social Security Act (42 U.S.C. 1395bb) is amend-
16 ed—

17 (A) in subsection (a)(1), as redesignated by
18 subsection (a)(2), by striking “In addition, if” and
19 inserting “If”;

20 (B) in subsection (b), as so redesignated—

21 (i) by striking “released to him by the
22 Joint Commission on Accreditation of Hos-
23 pitals,” and inserting “released to the Secretary
24 by”; and

1 (ii) by striking the comma after “Associa-
2 tion”;

3 (C) in subsection (c), as so redesignated, by
4 striking “pursuant to subsection (a) or (b)(1)” and
5 inserting “pursuant to subsection (a)(1)”; and

6 (D) in subsection (d), as so redesignated, by
7 striking “pursuant to subsection (a) or (b)(1)” and
8 inserting “pursuant to subsection (a)(1)”.

9 (2) Section 1861(e) of the Social Security Act (42
10 U.S.C. 1395x(e)) is amended in the fourth sentence by
11 striking “and (ii) is accredited by the Joint Commission
12 on Accreditation of Hospitals, or is accredited by or ap-
13 proved by a program of the country in which such institu-
14 tion is located if the Secretary finds the accreditation or
15 comparable approval standards of such program to be es-
16 sentially equivalent to those of the Joint Commission on
17 Accreditation of Hospitals” and inserting “and (ii) is ac-
18 credited by a national accreditation body recognized by the
19 Secretary under section 1865(a), or is accredited by or
20 approved by a program of the country in which such insti-
21 tution is located if the Secretary finds the accreditation
22 or comparable approval standards of such program to be
23 essentially equivalent to those of such a national accredita-
24 tion body.”.

1 (3) Section 1864(c) of the Social Security Act (42
2 U.S.C. 1395aa(c)) is amended by striking “pursuant to
3 subsection (a) or (b)(1) of section 1865” and inserting
4 “pursuant to section 1865(a)(1)”.

5 (4) Section 1875(b) of the Social Security Act (42
6 U.S.C. 1395ll(b)) is amended by striking “the Joint Com-
7 mission on Accreditation of Hospitals,” and inserting “na-
8 tional accreditation bodies under section 1865(a)”.

9 (5) Section 1834(a)(20)(B) of the Social Security Act
10 (42 U.S.C. 1395m(a)(20)(B)) is amended by striking
11 “section 1865(b)” and inserting “section 1865(a)”.

12 (6) Section 1852(e)(4)(C) of the Social Security Act
13 (42 U.S.C. 1395w-22(e)(4)(C)) is amended by striking
14 “section 1865(b)(2)” and inserting “section 1865(a)(2)”.

15 (c) AUTHORITY TO RECOGNIZE THE JOINT COMMIS-
16 SION AS A NATIONAL ACCREDITATION BODY.—The Sec-
17 retary of Health and Human Services may recognize the
18 Joint Commission as a national accreditation body under
19 section 1865 of the Social Security Act (42 U.S.C.
20 1395bb), as amended by this section, upon such terms and
21 conditions, and upon submission of such information, as
22 the Secretary may require.

23 (d) EFFECTIVE DATE; TRANSITION RULE.—(1) Sub-
24 ject to paragraph (2), the amendments made by this sec-
25 tion shall apply with respect to accreditations of hospitals

1 granted on or after the date that is 24 months after the
2 date of the enactment of this Act.

3 (2) For purposes of title XVIII of the Social Security
4 Act (42 U.S.C. 1395 et seq.), the amendments made by
5 this section shall not effect the accreditation of a hospital
6 by the Joint Commission, or under accreditation or com-
7 parable approval standards found to be essentially equiva-
8 lent to accreditation or approval standards of the Joint
9 Commission, for the period of time applicable under such
10 accreditation.

11 **Subtitle C—Provisions Relating to** 12 **Part B**

13 **PART I—PHYSICIANS' SERVICES**

14 **SEC. 131. PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY** 15 **IMPROVEMENTS.**

16 (a) IN GENERAL.—

17 (1) INCREASE IN UPDATE FOR THE SECOND
18 HALF OF 2008 AND FOR 2009.—

19 (A) FOR THE SECOND HALF OF 2008.—

20 Section 1848(d)(8) of the Social Security Act
21 (42 U.S.C. 1395w-4(d)(8)), as added by section
22 101 of the Medicare, Medicaid, and SCHIP Ex-
23 tension Act of 2007 (Public Law 110-173), is
24 amended—

(i) in the heading, by striking “A PORTION OF”;

(ii) in subparagraph (A), by striking “for the period beginning on January 1, 2008, and ending on June 30, 2008,”; and

(iii) in subparagraph (B)—

(I) in the heading, by striking “THE REMAINING PORTION OF 2008 AND”; and

(II) by striking “for the period beginning on July 1, 2008, and ending on December 31, 2008, and”.

(B) FOR 2009.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)), as amended by section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), is amended by adding at the end the following new paragraph:

“(9) UPDATE FOR 2009.—

“(A) IN GENERAL.—Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

1 “(B) NO EFFECT ON COMPUTATION OF
2 CONVERSION FACTOR FOR 2010 AND SUBSE-
3 QUENT YEARS.—The conversion factor under
4 this subsection shall be computed under para-
5 graph (1)(A) for 2010 and subsequent years as
6 if subparagraph (A) had never applied.”.

7 (2) BENEFICIARY PREMIUM PROTECTION.—Sec-
8 tion 1839(g) of the Social Security Act (42 U.S.C.
9 1395r(g)) is amended—

10 (A) by redesignating paragraphs (1) and
11 (2) as subparagraphs (A) and (B), respectively,
12 and moving such subparagraphs 2 ems to the
13 right;

14 (B) in the matter preceding paragraph (1),
15 by striking “shall exclude an estimate” and in-
16 serting “shall exclude—
17 “(1) an estimate”; and

18 (C) by adding at the end the following new
19 paragraph:

20 “(2) with respect to the monthly premium rate
21 under subsection (a)(3) for 2009, \$1,200,000,000 of
22 benefits and administrative costs.”.

23 (3) REVISION OF THE PHYSICIAN ASSISTANCE
24 AND QUALITY INITIATIVE FUND.—Section 1848(l)(2)
25 of the Social Security Act (42 U.S.C. 1395w—

4(l)(2)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(A) in subparagraph (A)—

(i) by striking clause (i)(III); and

(ii) by striking clause (ii)(III); and

(B) in subparagraph (B)—

(i) in clause (i), by adding “and” at the end;

(ii) in clause (ii), by striking “; and” and inserting a period; and

(iii) by striking clause (iii).

(b) EXTENSION AND IMPROVEMENT OF THE QUALITY REPORTING SYSTEM.—

(1) SYSTEM.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)), as amended by section 101(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by adding at the end the following new subparagraphs:

“(C) FOR 2010 AND SUBSEQUENT YEARS.—

“(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional serv-

1 ices furnished during 2010 and each subse-
2 quent year, subject to subsection
3 (m)(3)(C), the quality measures (including
4 electronic prescribing quality measures)
5 specified under this paragraph shall be
6 such measures selected by the Secretary
7 from measures that have been endorsed by
8 the entity with a contract with the Sec-
9 retary under section 1890(a).

10 “(ii) EXCEPTION.—In the case of a
11 specified area or medical topic determined
12 appropriate by the Secretary for which a
13 feasible and practical measure has not
14 been endorsed by the entity with a contract
15 under section 1890(a), the Secretary may
16 specify a measure that is not so endorsed
17 as long as due consideration is given to
18 measures that have been endorsed or
19 adopted by a consensus organization iden-
20 tified by the Secretary, such as the AQA
21 alliance.

22 “(D) OPPORTUNITY TO PROVIDE INPUT ON
23 MEASURES FOR 2009 AND SUBSEQUENT
24 YEARS.—For each quality measure (including
25 an electronic prescribing quality measure)

1 adopted by the Secretary under subparagraph
2 (B) (with respect to 2009) or subparagraph
3 (C), the Secretary shall ensure that eligible pro-
4 fessionals have the opportunity to provide input
5 during the development, endorsement, or selec-
6 tion of measures applicable to services they fur-
7 nish.”.

8 (2) REDESIGNATION OF REPORTING SYSTEM.—

9 Subsection (c) of section 101 of division B of the
10 Tax Relief and Health Care Act of 2006 (42 U.S.C.
11 1395w–4 note), as amended by section 101(b)(2) of
12 the Medicare, Medicaid, and SCHIP Extension Act
13 of 2007 (Public Law 110–173), is redesignated as
14 subsection (m) of section 1848 of the Social Security
15 Act.

16 (3) INCENTIVE PAYMENTS UNDER REPORTING
17 SYSTEM.—Section 1848(m) of the Social Security
18 Act, as redesignated by paragraph (2), is amended—

19 (A) by amending the heading to read as
20 follows: “INCENTIVE PAYMENTS FOR QUALITY
21 REPORTING”;

22 (B) by striking paragraph (1) and insert-
23 ing the following:

24 “(1) INCENTIVE PAYMENTS.—

1 “(A) IN GENERAL.—For 2007 through
2 2010, with respect to covered professional serv-
3 ices furnished during a reporting period by an
4 eligible professional, if—

5 “(i) there are any quality measures
6 that have been established under the physi-
7 cian reporting system that are applicable
8 to any such services furnished by such pro-
9 fessional for such reporting period; and

10 “(ii) the eligible professional satisfac-
11 torily submits (as determined under this
12 subsection) to the Secretary data on such
13 quality measures in accordance with such
14 reporting system for such reporting period,
15 in addition to the amount otherwise paid under
16 this part, there also shall be paid to the eligible
17 professional (or to an employer or facility in the
18 cases described in clause (A) of section
19 1842(b)(6)) or, in the case of a group practice
20 under paragraph (3)(C), to the group practice,
21 from the Federal Supplementary Medical Insur-
22 ance Trust Fund established under section
23 1841 an amount equal to the applicable quality
24 percent of the Secretary’s estimate (based on
25 claims submitted not later than 2 months after

the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

“(B) APPLICABLE QUALITY PERCENT.—

For purposes of subparagraph (A), the term ‘applicable quality percent’ means—

“(i) for 2007 and 2008, 1.5 percent;

and

“(ii) for 2009 and 2010, 2.0 percent.”;

(C) by striking paragraph (3) and redesignating paragraph (2) as paragraph (3);

(D) in paragraph (3), as so redesignated—

(i) in the matter preceding subparagraph (A), by striking “For purposes” and inserting the following:

“(A) IN GENERAL.—For purposes”;

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and moving the indentation of such clauses 2 ems to the right;

1 (iii) in subparagraph (A), as added by
2 clause (i), by adding at the end the fol-
3 lowing flush sentence:

4 “For years after 2008, quality measures for
5 purposes of this subparagraph shall not include
6 electronic prescribing quality measures.”; and

7 (iv) by adding at the end the following
8 new subparagraphs:

9 “(C) SATISFACTORY REPORTING MEAS-
10 URES FOR GROUP PRACTICES.—

11 “(i) IN GENERAL.—By January 1,
12 2010, the Secretary shall establish and
13 have in place a process under which eligi-
14 ble professionals in a group practice (as
15 defined by the Secretary) shall be treated
16 as satisfactorily submitting data on quality
17 measures under subparagraph (A) and as
18 meeting the requirement described in sub-
19 paragraph (B)(ii) for covered professional
20 services for a reporting period (or, for pur-
21 poses of subsection (a)(5), for a reporting
22 period for a year) if, in lieu of reporting
23 measures under subsection (k)(2)(C), the
24 group practice reports measures deter-
25 mined appropriate by the Secretary, such

as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

“(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i) shall provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

“(iii) NO DOUBLE PAYMENTS.—Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

“(D) AUTHORITY TO REVISE SATISFACTORILY REPORTING DATA.—For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subpara-

1 graph (A) and the criteria for submitting data
2 on electronic prescribing quality measures
3 under subparagraph (B)(ii).”;

4 (E) in paragraph (5)—

5 (i) in subparagraph (C), by inserting
6 “for 2007, 2008, and 2009,” after “provi-
7 sion of law,”;

8 (ii) in subparagraph (D)—

9 (I) in clause (i)—

10 (aa) by inserting “for 2007
11 and 2008” after “under this sub-
12 section”; and

13 (bb) by striking “paragraph
14 (2)” and inserting “this sub-
15 section”;

16 (II) in clause (ii), by striking
17 “shall” and inserting “may establish
18 procedures to”; and

19 (III) in clause (iii)—

20 (aa) by inserting “(or, in the
21 case of a group practice under
22 paragraph (3)(C), the group
23 practice)” after “an eligible pro-
24 fessional”;

(bb) by striking “bonus incentive payment” and inserting “incentive payment under this subsection”; and

(cc) by adding at the end the following new sentence: “If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).”;

(iii) in subparagraph (E)—

(I) by striking “(I) IN GENERAL.—”;

(II) by striking clause (ii);

(III) by redesignating subclauses

(I) through (IV) as clauses (i) through (iv), respectively, and moving the indentation of such clauses 2 ems to the left;

(IV) in clause (ii), as so redesignated, by striking “paragraph (2)” and inserting “this subsection”; and

(V) in clause (iv), as so redesignated—

1 (aa) by striking “the bonus”
2 and inserting “any”; and

3 (bb) by inserting “and the
4 payment adjustment under sub-
5 section (a)(5)(A)” before the pe-
6 riod at the end;

7 (iv) in subparagraph (F)—

8 (I) by striking “2009, paragraph
9 (3) shall not apply, and” and insert-
10 ing “subsequent years,”; and

11 (II) by striking “paragraph (2)”
12 and inserting “this subsection”; and

13 (v) by adding at the end the following
14 new subparagraph:

15 “(G) POSTING ON WEBSITE.—The Sec-
16 retary shall post on the Internet website of the
17 Centers for Medicare & Medicaid Services, in an
18 easily understandable format, a list of the
19 names of the following:

20 “(i) The eligible professionals (or, in
21 the case of reporting under paragraph
22 (3)(C), the group practices) who satisfac-
23 torily submitted data on quality measures
24 under this subsection.

“(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.”; and (F) in paragraph (6), by striking subparagraph (C) and inserting the following:

“(C) REPORTING PERIOD.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term ‘reporting period’ means—

“(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

“(II) for 2008, 2009, 2010, and 2011, the entire year.

“(ii) AUTHORITY TO REVISE REPORTING PERIOD.—For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding

1 sentence, the term ‘reporting period’ shall
2 mean such revised period.

3 “(iii) REFERENCE.—Any reference in
4 this subsection to a reporting period with
5 respect to the application of subsection
6 (a)(5) shall be deemed a reference to the
7 reporting period under subparagraph
8 (D)(iii) of such subsection.”.

9 (4) INCLUSION OF QUALIFIED AUDIOLOGISTS
10 AS ELIGIBLE PROFESSIONALS.—

11 (A) IN GENERAL.—Section 1848(k)(3)(B)
12 of the Social Security Act (42 U.S.C. 1395w–
13 4(k)(3)(B)), is amended by adding at the end
14 the following new clause:

15 “(iv) Beginning with 2009, a qualified
16 audiologist (as defined in section
17 1861(ll)(3)(B)).”.

18 (B) NO CHANGE IN BILLING.—Nothing in
19 the amendment made by subparagraph (A)
20 shall be construed to change the way in which
21 billing for audiology services (as defined in sec-
22 tion 1861(ll)(2) of the Social Security Act (42
23 U.S.C. 1395x(ll)(2))) occurs under title XVIII
24 of such Act as of July 1, 2008.

(5) CONFORMING AMENDMENTS.—Section 1848(m) of the Social Security Act, as added and amended by paragraphs (2) and (3), is amended—

(A) in paragraph (5)—

(i) in subparagraph (A)—

(I) by striking “section 1848(k) of the Social Security Act, as added by subsection (b),” and inserting “subsection (k)”; and

(II) by striking “such section” and inserting “such subsection”;

(ii) in subparagraph (B), by striking “of the Social Security Act (42 U.S.C. 1395l)”; and

(iii) in subparagraph (E), in the matter preceding clause (i), by striking “1869 or 1878 of the Social Security Act or otherwise” and inserting “1869, section 1878, or otherwise”; and

(iv) in subparagraph (F)—

(I) by striking “paragraph (2)(B) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w-4(k))” and inserting “subsection (k)(2)(B)”; and

1 (II) by striking “paragraph (4)
2 of such section” and inserting “sub-
3 section (k)(4)”;

4 (B) in paragraph (6)—

5 (i) in subparagraph (A), by striking
6 “section 1848(k)(3) of the Social Security
7 Act, as added by subsection (b)” and in-
8 serting “subsection (k)(3)”; and

9 (ii) in subparagraph (B), by striking
10 “section 1848(k) of the Social Security
11 Act, as added by subsection (b)” and in-
12 serting “subsection (k)”; and

13 (C) by striking paragraph (6)(D).

14 (6) NO AFFECT ON INCENTIVE PAYMENTS FOR
15 2007 OR 2008.—Nothing in the amendments made by
16 this subsection or section 132 shall affect the oper-
17 ation of the provisions of section 1848(m) of the So-
18 cial Security Act, as redesignated and amended by
19 such subsection and section, with respect to 2007 or
20 2008.

21 (c) PHYSICIAN FEEDBACK PROGRAM TO IMPROVE
22 EFFICIENCY AND CONTROL COSTS.—

23 (1) IN GENERAL.—Section 1848 of the Social
24 Security Act (42 U.S.C. 1395w-4), as amended by

subsection (b), is amended by adding at the end the following new subsection:

“(n) PHYSICIAN FEEDBACK PROGRAM.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the ‘Program’) under which the Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

“(B) RESOURCE USE.—The resources described in subparagraph (A) may be measured—

“(i) on an episode basis;

“(ii) on a per capita basis; or

“(iii) on both an episode and a per capita basis.

1 “(2) IMPLEMENTATION.—The Secretary shall
2 implement the Program by not later than January
3 1, 2009.

4 “(3) DATA FOR REPORTS.—To the extent prac-
5 ticable, reports under the Program shall be based on
6 the most recent data available.

7 “(4) AUTHORITY TO FOCUS APPLICATION.—The
8 Secretary may focus the application of the Program
9 as appropriate, such as focusing the Program on—

10 “(A) physician specialties that account for
11 a certain percentage of all spending for physi-
12 cians’ services under this title;

13 “(B) physicians who treat conditions that
14 have a high cost or a high volume, or both,
15 under this title;

16 “(C) physicians who use a high amount of
17 resources compared to other physicians;

18 “(D) physicians practicing in certain geo-
19 graphic areas; or

20 “(E) physicians who treat a minimum
21 number of individuals under this title.

22 “(5) AUTHORITY TO EXCLUDE CERTAIN INFOR-
23 MATION IF INSUFFICIENT INFORMATION.—The Sec-
24 retary may exclude certain information regarding a
25 service from a report under the Program with re-

1 spect to a physician (or group of physicians) if the
2 Secretary determines that there is insufficient infor-
3 mation relating to that service to provide a valid re-
4 port on that service.

5 “(6) ADJUSTMENT OF DATA.—To the extent
6 practicable; the Secretary shall make appropriate ad-
7 justments to the data used in preparing reports
8 under the Program, such as adjustments to take
9 into account variations in health status and other
10 patient characteristics.

11 “(7) EDUCATION AND OUTREACH.—The Sec-
12 retary shall provide for education and outreach ac-
13 tivities to physicians on the operation of, and meth-
14 odologies employed under, the Program.

15 “(8) DISCLOSURE EXEMPTION.—Reports under
16 the Program shall be exempt from disclosure under
17 section 552 of title 5, United States Code.”.

18 (2) GAO STUDY AND REPORT ON THE PHYSI-
19 CIAN FEEDBACK PROGRAM.—

20 (A) STUDY.—The Comptroller General of
21 the United States shall conduct a study of the
22 Physician Feedback Program conducted under
23 section 1848(n) of the Social Security Act, as
24 added by paragraph (1), including the imple-
25 mentation of the Program.

1 (B) REPORT.—Not later than March 1,
2 2011, the Comptroller General of the United
3 States shall submit a report to Congress con-
4 taining the results of the study conducted under
5 subparagraph (A), together with recommenda-
6 tions for such legislation and administrative ac-
7 tion as the Comptroller General determines ap-
8 propriate.

9 (d) PLAN FOR TRANSITION TO VALUE-BASED PUR-
10 CHASING PROGRAM FOR PHYSICIANS AND OTHER PRACTI-
11 TIONERS.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services shall develop a plan to transition to
14 a value-based purchasing program for payment
15 under the Medicare program for covered professional
16 services (as defined in section 1848(k)(3)(A) of the
17 Social Security Act (42 U.S.C. 1395w–4(k)(3)(A))).
18 The Secretary shall consult with the Medicare Pay-
19 ment Advisory Commission in the development of
20 such plan.

21 (2) REPORT.—Not later than May 1, 2010, the
22 Secretary of Health and Human Services shall sub-
23 mit a report to Congress containing the plan devel-
24 oped under paragraph (1), together with rec-

ommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 132. INCENTIVES FOR ELECTRONIC PRESCRIBING.

(a) INCENTIVE PAYMENTS.—Section 1848(m) of the Social Security Act, as added and amended by section 131(b), is amended—

(1) by inserting after paragraph (1), the following new paragraph:

“(2) INCENTIVE PAYMENTS FOR ELECTRONIC PRESCRIBING.—

“(A) IN GENERAL.—For 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable electronic prescribing percent of

1 the Secretary's estimate (based on claims sub-
2 mitted not later than 2 months after the end of
3 the reporting period) of the allowed charges
4 under this part for all such covered professional
5 services furnished by the eligible professional
6 (or, in the case of a group practice under para-
7 graph (3)(C), by the group practice) during the
8 reporting period.

9 “(B) LIMITATION WITH RESPECT TO ELEC-
10 TRONIC PRESCRIBING QUALITY MEASURES.—

11 The provisions of this paragraph and subsection
12 (a)(5) shall not apply to an eligible professional
13 (or, in the case of a group practice under para-
14 graph (3)(C), to the group practice) if, for the
15 reporting period (or, for purposes of subsection
16 (a)(5), for the reporting period for a year)—

17 “(i) the allowed charges under this
18 part for all covered professional services
19 furnished by the eligible professional (or
20 group, as applicable) for the codes to
21 which the electronic prescribing quality
22 measure applies (as identified by the Sec-
23 retary and published on the Internet
24 website of the Centers for Medicare &
25 Medicaid Services as of January 1, 2008,

and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

“(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

“(C) APPLICABLE ELECTRONIC PRESCRIBING PERCENT.—For purposes of subparagraph (A), the term ‘applicable electronic prescribing percent’ means—

“(i) for 2009 and 2010, 2.0 percent;

“(ii) for 2011 and 2012, 1.0 percent;

and

“(iii) for 2013, 0.5 percent.”;

(2) in paragraph (3), as redesignated by section

131(b)—

1 (A) in the heading, by inserting “AND SUC-
2 CESSFUL ELECTRONIC PRESCRIBER” after “RE-
3 PORTING”; and

4 (B) by inserting after subparagraph (A)
5 the following new subparagraph:

6 “(B) SUCCESSFUL ELECTRONIC PRE-
7 SCRIBER.—

8 “(i) IN GENERAL.—For purposes of
9 paragraph (2) and subsection (a)(5), an el-
10 igible professional shall be treated as a
11 successful electronic prescriber for a re-
12 porting period (or, for purposes of sub-
13 section (a)(5), for the reporting period for
14 a year) if the eligible professional meets
15 the requirement described in clause (ii), or,
16 if the Secretary determines appropriate,
17 the requirement described in clause (iii). If
18 the Secretary makes the determination
19 under the preceding sentence to apply the
20 requirement described in clause (iii) for a
21 period, then the requirement described in
22 clause (ii) shall not apply for such period.

23 “(ii) REQUIREMENT FOR SUBMITTING
24 DATA ON ELECTRONIC PRESCRIBING QUAL-
25 ITY MEASURES.—The requirement de-

scribed in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

“(iii) REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

1 “(iv) USE OF PART D DATA.—Not-
2 withstanding sections 1860D–15(d)(2)(B)
3 and 1860D–15(f)(2), the Secretary may
4 use data regarding drug claims submitted
5 for purposes of section 1860D–15 that are
6 necessary for purposes of clause (iii), para-
7 graph (2)(B)(ii), and paragraph (5)(G).

8 “(v) STANDARDS FOR ELECTRONIC
9 PRESCRIBING.—To the extent practicable,
10 in determining whether eligible profes-
11 sionals meet the requirements under
12 clauses (ii) and (iii) for purposes of clause
13 (i), the Secretary shall ensure that eligible
14 professionals utilize electronic prescribing
15 systems in compliance with standards es-
16 tablished for such systems pursuant to the
17 Part D Electronic Prescribing Program
18 under section 1860D–4(e).”; and

19 (3) in paragraph (5)(E), by striking clause (iii)
20 and inserting the following new clause:

21 “(iii) the determination of a successful
22 electronic prescriber under paragraph (3),
23 the limitation under paragraph (2)(B), and
24 the exception under subsection (a)(5)(B);
25 and”.

1 (b) INCENTIVE PAYMENT ADJUSTMENT.—Section
2 1848(a) of the Social Security Act (42 U.S.C. 1395w—
3 4(a)) is amended by adding at the end the following new
4 paragraph:

5 “(5) INCENTIVES FOR ELECTRONIC PRE-
6 SCRIBING.—

7 “(A) ADJUSTMENT.—

8 “(i) IN GENERAL.—Subject to sub-
9 paragraph (B) and subsection (m)(2)(B),
10 with respect to covered professional serv-
11 ices furnished by an eligible professional
12 during 2012 or any subsequent year, if the
13 eligible professional is not a successful
14 electronic prescriber for the reporting pe-
15 riod for the year (as determined under
16 subsection (m)(3)(B)), the fee schedule
17 amount for such services furnished by such
18 professional during the year (including the
19 fee schedule amount for purposes of deter-
20 mining a payment based on such amount)
21 shall be equal to the applicable percent of
22 the fee schedule amount that would other-
23 wise apply to such services under this sub-
24 section (determined after application of

1 paragraph (3) but without regard to this
2 paragraph).

3 “(ii) APPLICABLE PERCENT.—For
4 purposes of clause (i), the term ‘applicable
5 percent’ means—

6 “(I) for 2012, 99 percent;

7 “(II) for 2012, 98.5 percent; and

8 “(III) for 2014 and each subse-
9 quent year, 98 percent.

10 “(B) SIGNIFICANT HARDSHIP EXCEP-
11 TION.—The Secretary may, on a case-by-case
12 basis, exempt an eligible professional from the
13 application of the payment adjustment under
14 subparagraph (A) if the Secretary determines,
15 subject to annual renewal, that compliance with
16 the requirement for being a successful elec-
17 tronic prescriber would result in a significant
18 hardship, such as in the case of an eligible pro-
19 fessional who practices in a rural area without
20 sufficient Internet access.

21 “(C) APPLICATION.—

22 “(i) PHYSICIAN REPORTING SYSTEM
23 RULES.—Paragraphs (5), (6), and (8) of
24 subsection (k) shall apply for purposes of

1 this paragraph in the same manner as they
2 apply for purposes of such subsection.

3 “(ii) INCENTIVE PAYMENT VALIDA-
4 TION RULES.—Clauses (ii) and (iii) of sub-
5 section (m)(5)(D) shall apply for purposes
6 of this paragraph in a similar manner as
7 they apply for purposes of such subsection.

8 “(D) DEFINITIONS.—For purposes of this
9 paragraph:

10 “(i) ELIGIBLE PROFESSIONAL; COV-
11 ERED PROFESSIONAL SERVICES.—The
12 terms ‘eligible professional’ and ‘covered
13 professional services’ have the meanings
14 given such terms in subsection (k)(3).

15 “(ii) PHYSICIAN REPORTING SYS-
16 TEM.—The term ‘physician reporting sys-
17 tem’ means the system established under
18 subsection (k).

19 “(iii) REPORTING PERIOD.—The term
20 ‘reporting period’ means, with respect to a
21 year, a period specified by the Secretary.”.

22 (c) GAO REPORT ON ELECTRONIC PRESCRIBING.—

23 Not later than September 1, 2012, the Comptroller Gen-
24 eral of the United States shall submit to Congress a report
25 on the implementation of the incentives for electronic pre-

1 scribing established under the provisions of, and amend-
2 ments made by, this section. Such report shall include in-
3 formation regarding the following:

4 (1) The percentage of eligible professionals (as
5 defined in section 1848(k)(3) of the Social Security
6 Act (42 U.S.C. 1395w-4(k)(3)) that are using elec-
7 tronic prescribing systems, including a determination
8 of whether less than 50 percent of eligible profes-
9 sionals are using electronic prescribing systems.

10 (2) If less than 50 percent of eligible profes-
11 sionals are using electronic prescribing systems, rec-
12 ommendations for increasing the use of electronic
13 prescribing systems by eligible professionals, such as
14 changes to the incentive payment adjustments estab-
15 lished under section 1848(a)(5) of such Act, as
16 added by subsection (b).

17 (3) The estimated savings to the Medicare pro-
18 gram under title XVIII of such Act resulting from
19 the use of electronic prescribing systems.

20 (4) Reductions in avoidable medical errors re-
21 sulting from the use of electronic prescribing sys-
22 tems.

23 (5) The extent to which the privacy and secu-
24 rity of the personal health information of Medicare
25 beneficiaries is protected when such beneficiaries'

1 prescription drug data and usage information is
2 used for purposes other than their direct clinical
3 care, including—

4 (A) whether information identifying the
5 beneficiary is, and remains, removed from data
6 regarding the beneficiary's prescription drug
7 utilization; and

8 (B) the extent to which current law re-
9 quires sufficient and appropriate oversight and
10 audit capabilities to monitor the practice of pre-
11 scription drug data mining.

12 (6) Such other recommendations and adminis-
13 trative action as the Comptroller General determines
14 to be appropriate.

15 **SEC. 133. EXPANDING ACCESS TO PRIMARY CARE SERV-**
16 **ICES.**

17 (a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY
18 CARE SERVICES FURNISHED IN PHYSICIAN SCARCITY
19 AREAS.—

20 (1) IN GENERAL.—Section 1833 of the Social
21 Security Act (42 U.S.C. 1395l) is amended by add-
22 ing at the end the following new subsection:

23 “(v) INCENTIVE PAYMENTS FOR PRIMARY CARE
24 SERVICES FURNISHED IN PHYSICIAN SCARCITY AREAS.—

1 “(1) IN GENERAL.—In the case of primary care
2 services furnished on or after January 1, 2011, by
3 a primary care physician in a primary care scarcity
4 county, in addition to the amount of payment that
5 would otherwise be made for such services under this
6 part, there also shall be paid (on a monthly or quar-
7 terly basis) an amount equal to 5 percent of the pay-
8 ment amount for the service under this part.

9 “(2) DEFINITIONS.—In this subsection:

10 “(A) PRIMARY CARE PHYSICIAN.—The
11 term ‘primary care physician’ means a physi-
12 cian (as described in section 1861(r)(1)) for
13 whom primary care services accounted for at
14 least a specified percent (as determined by the
15 Secretary) of the allowed charges under this
16 part for such physician in a prior period as de-
17 termined appropriate by the Secretary.

18 “(B) PRIMARY CARE SCARCITY COUNTY.—
19 The term ‘primary care scarcity county’ means
20 the primary care scarcity counties that the Sec-
21 retary was using under subsection (u) with re-
22 spect to physicians’ services furnished on De-
23 cember 31, 2007.

24 “(C) PRIMARY CARE SERVICES.—The term
25 ‘primary care services’ means procedure codes

1 for services in the category of the Healthcare
2 Common Procedure Coding System, as estab-
3 lished by the Secretary under section
4 1848(c)(5) (as of December 31, 2008 and as
5 subsequently modified by the Secretary) con-
6 sisting of evaluation and management services,
7 but limited to such procedure codes in the cat-
8 egory of office or other outpatient services, and
9 consisting of subcategories of such procedure
10 codes for services for both new and established
11 patients.

12 “(3) JUDICIAL REVIEW.—There shall be no ad-
13 ministrative or judicial review under section 1869,
14 1878, or otherwise, respecting the identification of
15 primary care physicians, primary care specialty
16 areas, or primary care services under this sub-
17 section.”.

18 (2) CONFORMING AMENDMENT.—Section
19 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
20 1395m(g)(2)(B)) is amended by adding at the end
21 the following sentence: “Section 1833(v) shall not be
22 taken into account in determining the amounts that
23 would otherwise be paid pursuant to the preceding
24 sentence.”.

1 (b) REVISIONS TO THE MEDICARE MEDICAL HOME
2 DEMONSTRATION PROJECT.—

3 (1) AUTHORITY TO EXPAND.—Section 204(b)
4 of division B of the Tax Relief and Health Care Act
5 of 2006 (42 U.S.C. 1395b–1 note) is amended—

6 (A) in paragraph (1), by striking “The
7 project” and inserting “Subject to paragraph
8 (3), the project”; and

9 (B) by adding at the end the following new
10 paragraph:

11 “(3) EXPANSION.—The Secretary may expand
12 the duration and the scope of the project under
13 paragraph (1), to an extent determined appropriate
14 by the Secretary, if the Secretary determines that
15 such expansion will result in any of the following
16 conditions being met:

17 “(A) The expansion of the project is ex-
18 pected to improve the quality of patient care
19 without increasing spending under the Medicare
20 program (not taking into account amounts
21 available under subsection (g)).

22 “(B) The expansion of the project is ex-
23 pected to reduce spending under the Medicare
24 program (not taking into account amounts

available under subsection (g)) without reducing the quality of patient care.”.

(2) FUNDING AND APPLICATION.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b–1 note) is amended by adding at the end the following new subsections:

“(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of \$100,000,000 to carry out the project.

“(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.”.

(c) APPLICATION OF BUDGET-NEUTRALITY ADJUSTOR TO CONVERSION FACTOR.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by inserting at the end the following new clause:

“(iv) ALTERNATIVE APPLICATION OF BUDGET-NEUTRALITY ADJUSTMENT.—Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of

1 continuing to apply budget-neutrality ad-
 2 justments required under clause (ii) for
 3 2007 and 2008 to work relative value
 4 units, the Secretary shall apply such budg-
 5 et-neutrality adjustments to the conversion
 6 factor otherwise determined for years be-
 7 ginning with 2009.”.

8 **SEC. 134. EXTENSION OF FLOOR ON MEDICARE WORK GEO-**
 9 **GRAPHIC ADJUSTMENT UNDER THE MEDI-**
 10 **CARE PHYSICIAN FEE SCHEDULE.**

11 (a) IN GENERAL.—Section 1848(e)(1)(E) of the So-
 12 cial Security Act (42 U.S.C. 1395w-4(e)(1)(E)), as
 13 amended by section 103 of the Medicare, Medicaid, and
 14 SCHIP Extension Act of 2007 (Public Law 110-173), is
 15 amended by striking “before July 1, 2008” and inserting
 16 “before January 1, 2010”.

17 (b) TREATMENT OF PHYSICIANS’ SERVICES FUR-
 18 NISHED IN CERTAIN AREAS.—Section 1848(e)(1)(G) of
 19 the Social Security Act (42 U.S.C. 1395w-4(e)(1)(G)) is
 20 amended by adding at the end the following new sentence:
 21 “For purposes of payment for services furnished in the
 22 State described in the preceding sentence on or after Jan-
 23 uary 1, 2009, after calculating the work geographic index
 24 in subparagraph (A)(iii), the Secretary shall increase the

1 work geographic index to 1.5 if such index would otherwise
2 be less than 1.5”.

3 (c) TECHNICAL CORRECTION.—Section 602(1) of the
4 Medicare Prescription Drug, Improvement, and Mod-
5 ernization Act of 2003 (Public Law 108–173; 117 Stat.
6 2301) is amended to read as follows:

7 “(1) in subparagraph (A), by striking ‘subpara-
8 graphs (B), (C), and (E)’ and inserting ‘subpara-
9 graphs (B), (C), (E), and (G)’; and”.

10 **SEC. 135. IMAGING PROVISIONS.**

11 (a) ACCREDITATION REQUIREMENT.—

12 (1) ACCREDITATION REQUIREMENT.—Section
13 1834 of the Social Security Act (42 U.S.C. 1395m)
14 is amended by inserting after subsection (d) the fol-
15 lowing new subsection:

16 “(e) ACCREDITATION REQUIREMENT FOR ADVANCED
17 DIAGNOSTIC IMAGING SERVICES.—

18 “(1) IN GENERAL.—

19 “(A) IN GENERAL.—Beginning with Janu-
20 ary 1, 2012, with respect to the technical com-
21 ponent of advanced diagnostic imaging services
22 for which payment is made under the fee sched-
23 ule established under section 1848(b) and that
24 are furnished by a supplier, payment may only
25 be made if such supplier is accredited by an ac-

1 creditation organization designated by the Sec-
2 retary under paragraph (2)(B)(i).

3 “(B) ADVANCED DIAGNOSTIC IMAGING
4 SERVICES DEFINED.—In this subsection, the
5 term ‘advanced diagnostic imaging services’ in-
6 cludes—

7 “(i) diagnostic magnetic resonance
8 imaging, computed tomography, and nu-
9 clear medicine (including positron emission
10 tomography); and

11 “(ii) such other diagnostic imaging
12 services, including services described in
13 section 1848(b)(4)(B) (excluding X-ray,
14 ultrasound, and fluoroscopy), as specified
15 by the Secretary in consultation with phy-
16 sician specialty organizations and other
17 stakeholders.

18 “(C) SUPPLIER DEFINED.—In this sub-
19 section, the term ‘supplier’ has the meaning
20 given such term in section 1861(d).

21 “(2) ACCREDITATION ORGANIZATIONS.—

22 “(A) FACTORS FOR DESIGNATION OF AC-
23 CREDITATION ORGANIZATIONS.—The Secretary
24 shall consider the following factors in desig-
25 nating accreditation organizations under sub-

1 paragraph (B)(i) and in reviewing and modi-
2 fying the list of accreditation organizations des-
3 ignated pursuant to subparagraph (C):

4 “(i) The ability of the organization to
5 conduct timely reviews of accreditation ap-
6 plications.

7 “(ii) Whether the organization has es-
8 tablished a process for the timely integra-
9 tion of new advanced diagnostic imaging
10 services into the organization’s accredita-
11 tion program.

12 “(iii) Whether the organization uses
13 random site visits, site audits, or other
14 strategies for ensuring accredited suppliers
15 maintain adherence to the criteria de-
16 scribed in paragraph (3).

17 “(iv) The ability of the organization
18 to take into account the capacities of sup-
19 pliers located in a rural area (as defined in
20 section 1886(d)(2)(D)).

21 “(v) Whether the organization has es-
22 tablished reasonable fees to be charged to
23 suppliers applying for accreditation.

24 “(vi) Such other factors as the Sec-
25 retary determines appropriate.

1 “(B) DESIGNATION.—Not later than Janu-
2 ary 1, 2010, the Secretary shall designate orga-
3 nizations to accredit suppliers furnishing the
4 technical component of advanced diagnostic im-
5 aging services. The list of accreditation organi-
6 zations so designated may be modified pursuant
7 to subparagraph (C).

8 “(C) REVIEW AND MODIFICATION OF LIST
9 OF ACCREDITATION ORGANIZATIONS.—

10 “(i) IN GENERAL.—The Secretary
11 shall review the list of accreditation organi-
12 zations designated under subparagraph (B)
13 taking into account the factors under sub-
14 paragraph (A). Taking into account the re-
15 sults of such review, the Secretary may, by
16 regulation, modify the list of accreditation
17 organizations designated under subpara-
18 graph (B).

19 “(ii) SPECIAL RULE FOR ACCREDITA-
20 TIONS DONE PRIOR TO REMOVAL FROM
21 LIST OF DESIGNATED ACCREDITATION OR-
22 GANIZATIONS.—In the case where the Sec-
23 retary removes an organization from the
24 list of accreditation organizations des-
25 ignated under subparagraph (B), any sup-

plier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

“(3) CRITERIA FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

“(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

“(B) standards for qualifications and responsibilities of medical directors and super-

1 vising physicians, including standards that rec-
2 ognize the considerations described in para-
3 graph (4);

4 “(C) procedures to ensure that equipment
5 used in furnishing the technical component of
6 advanced diagnostic imaging services meets per-
7 formance specifications;

8 “(D) standards that require the supplier
9 have procedures in place to ensure the safety of
10 persons who furnish the technical component of
11 advanced diagnostic imaging services and indi-
12 viduals to whom such services are furnished;

13 “(E) standards that require the establish-
14 ment and maintenance of a quality assurance
15 and quality control program by the supplier
16 that is adequate and appropriate to ensure the
17 reliability, clarity, and accuracy of the technical
18 quality of diagnostic images produced by such
19 supplier; and

20 “(F) any other standards or procedures
21 the Secretary determines appropriate.

22 “(4) RECOGNITION IN STANDARDS FOR THE
23 EVALUATION OF MEDICAL DIRECTORS AND SUPER-
24 VISING PHYSICIANS.—The standards described in

1 paragraph (3)(B) shall recognize whether a medical
2 director or supervising physician—

3 “(A) in a particular specialty receives
4 training in advanced diagnostic imaging serv-
5 ices in a residency program;

6 “(B) has attained, through experience, the
7 necessary expertise to be a medical director or
8 a supervising physician;

9 “(C) has completed any continuing medical
10 education courses relating to such services; or

11 “(D) has met such other standards as the
12 Secretary determines appropriate.

13 “(5) RULE FOR ACCREDITATIONS MADE PRIOR
14 TO DESIGNATION.—In the case of a supplier that is
15 accredited before January 1, 2010, by an accredita-
16 tion organization designated by the Secretary under
17 paragraph (2)(B) as of January 1, 2010, such sup-
18 plier shall be considered to have been accredited by
19 an organization designated by the Secretary under
20 such paragraph as of January 1, 2012, for the re-
21 maining period such accreditation is in effect.”.

22 (2) CONFORMING AMENDMENTS.—

23 (A) IN GENERAL.—Section 1862(a) of the
24 Social Security Act (42 U.S.C. 1395y(a)) is
25 amended—

1 (i) in paragraph (21), by striking “or”
2 at the end;

3 (ii) in paragraph (22), by striking the
4 period at the end and inserting “; or”; and

5 (iii) by inserting after paragraph (22)
6 the following new paragraph:

7 “(23) which are the technical component of ad-
8 vanced diagnostic imaging services described in sec-
9 tion 1834(e)(1)(B) for which payment is made under
10 the fee schedule established under section 1848(b)
11 and that are furnished by a supplier (as defined in
12 section 1861(d)), if such supplier is not accredited
13 by an accreditation organization designated by the
14 Secretary under section 1834(e)(2)(B).”..

15 (B) EFFECTIVE DATE.—The amendments
16 made by this paragraph shall apply to advanced
17 diagnostic imaging services furnished on or
18 after January 1, 2012.

19 (b) DEMONSTRATION PROJECT TO ASSESS THE AP-
20 PROPRIATE USE OF IMAGING SERVICES.—

21 (1) CONDUCT OF DEMONSTRATION PROJECT.—

22 (A) IN GENERAL.—The Secretary of
23 Health and Human Services (in this section re-
24 ferred to as the “Secretary”) shall conduct a
25 demonstration project using the models de-

scribed in paragraph (2)(E) to collect data regarding physician compliance with appropriateness criteria selected under paragraph (2)(D) in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

(B) ADVANCED DIAGNOSTIC IMAGING SERVICES.—In this subsection, the term “advanced diagnostic imaging services” has the meaning given such term in section 1834(e)(1)(B) of the Social Security Act, as added by subsection (a).

(C) AUTHORITY TO FOCUS DEMONSTRATION PROJECT.—The Secretary may focus the demonstration project with respect to certain advanced diagnostic imaging services, such as services that account for a large amount of expenditures under the Medicare program, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exists.

(2) IMPLEMENTATION AND DESIGN OF DEMONSTRATION PROJECT.—

(A) IMPLEMENTATION AND DURATION.—

1 (i) IMPLEMENTATION.—The Secretary
2 shall implement the demonstration project
3 under this subsection not later than Janu-
4 ary 1, 2010.

5 (ii) DURATION.—The Secretary shall
6 conduct the demonstration project under
7 this subsection for a 2-year period.

8 (B) APPLICATION AND SELECTION OF PAR-
9 TICIPATING PHYSICIANS.—

10 (i) APPLICATION.—Each physician
11 that desires to participate in the dem-
12 onstration project under this subsection
13 shall submit an application to the Sec-
14 retary at such time, in such manner, and
15 containing such information as the Sec-
16 retary may require.

17 (ii) SELECTION.—The Secretary shall
18 select physicians to participate in the dem-
19 onstration project under this subsection
20 from among physicians submitting applica-
21 tions under clause (i). The Secretary shall
22 ensure that the physicians selected—

23 (I) represent a wide range of geo-
24 graphic areas, demographic character-
25 istics (such as urban, rural, and sub-

1 urban), and practice settings (such as
2 private and academic practices); and

3 (II) have the capability to submit
4 data to the Secretary (or an entity
5 under a subcontract with the Sec-
6 retary) in an electronic format in ac-
7 cordance with standards established
8 by the Secretary.

9 (C) ADMINISTRATIVE COSTS AND INCEN-
10 TIVES.—The Secretary shall—

11 (i) reimburse physicians for reason-
12 able administrative costs incurred in par-
13 ticipating in the demonstration project
14 under this subsection; and

15 (ii) provide reasonable incentives to
16 physicians to encourage participation in
17 the demonstration project under this sub-
18 section.

19 (D) USE OF APPROPRIATENESS CRI-
20 TERIA.—

21 (i) IN GENERAL.—The Secretary, in
22 consultation with medical specialty soci-
23 eties and other stakeholders, shall select
24 criteria with respect to the clinical appro-
25 priateness of advanced diagnostic imaging

1 services for use in the demonstration
2 project under this subsection.

3 (ii) CRITERIA SELECTED.—Any cri-
4 teria selected under clause (i) shall—

5 (I) be developed or endorsed by a
6 medical specialty society; and

7 (II) be developed in adherence to
8 appropriateness principles developed
9 by a consensus organization, such as
10 the AQA alliance.

11 (E) MODELS FOR COLLECTING DATA RE-
12 GARDING PHYSICIAN COMPLIANCE WITH SE-
13 LECTED CRITERIA.—Subject to subparagraph
14 (H), in carrying out the demonstration project
15 under this subsection, the Secretary shall use
16 each of the following models for collecting data
17 regarding physician compliance with appro-
18 priateness criteria selected under subparagraph
19 (D):

20 (i) A model described in subparagraph
21 (F).

22 (ii) A model described in subpara-
23 graph (G).

24 (iii) Any other model that the Sec-
25 retary determines to be useful in evalu-

1 ating the use of appropriateness criteria
2 for advanced diagnostic imaging services.

3 (F) POINT OF SERVICE MODEL DE-
4 SCRIBED.—A model described in this subpara-
5 graph is a model that—

6 (i) uses an electronic or paper intake
7 form that—

8 (I) contains a certification by the
9 physician furnishing the imaging serv-
10 ice that the data on the intake form
11 was confirmed with the Medicare ben-
12 eficiary before the service was fur-
13 nished;

14 (II) contains standardized data
15 elements for diagnosis, service or-
16 dered, service furnished, and such
17 other information determined by the
18 Secretary, in consultation with med-
19 ical specialty societies and other
20 stakeholders, to be germane to evalu-
21 ating the effectiveness of the use of
22 appropriateness criteria selected under
23 subparagraph (D); and

24 (III) is accessible to physicians
25 participating in the demonstration

1 project under this subsection in a for-
2 mat that allows for the electronic sub-
3 mission of such form; and

4 (ii) provides for feedback reports in
5 accordance with paragraph (3)(B).

6 (G) POINT OF ORDER MODEL DE-
7 SCRIBED.—A model described in this subpara-
8 graph is a model that—

9 (i) uses a computerized order-entry
10 system that requires the transmittal of rel-
11 evant supporting information at the time
12 of referral for advanced diagnostic imaging
13 services and provides automated decision-
14 support feedback to the referring physician
15 regarding the appropriateness of fur-
16 nishing such imaging services; and

17 (ii) provides for feedback reports in
18 accordance with paragraph (3)(B).

19 (H) LIMITATION.—In no case may the
20 Secretary use prior authorization—

21 (i) as a model for collecting data re-
22 garding physician compliance with appro-
23 priateness criteria selected under subpara-
24 graph (D) under the demonstration project
25 under this subsection; or

(ii) under any model used for collecting such data under the demonstration project.

(I) REQUIRED CONTRACTS AND PERFORMANCE STANDARDS FOR CERTAIN ENTITIES.—

(i) IN GENERAL.—The Secretary shall enter into contracts with entities to carry out the model described in subparagraph (G).

(ii) PERFORMANCE STANDARDS.—The Secretary shall establish and enforce performance standards for such entities under the contracts entered into under clause (i), including performance standards with respect to—

(I) the satisfaction of Medicare beneficiaries who are furnished advanced diagnostic imaging services by a physician participating in the demonstration project;

(II) the satisfaction of physicians participating in the demonstration project;

1 (III) if applicable, timelines for
2 the provision of feedback reports
3 under paragraph (3)(B); and
4 (IV) any other areas determined
5 appropriate by the Secretary.

6 (3) COMPARISON OF UTILIZATION OF AD-
7 VANCED DIAGNOSTIC IMAGING SERVICES AND FEED-
8 BACK REPORTS.—

9 (A) COMPARISON OF UTILIZATION OF AD-
10 VANCED DIAGNOSTIC IMAGING SERVICES.—The
11 Secretary shall consult with medical specialty
12 societies and other stakeholders to develop
13 mechanisms for comparing the utilization of ad-
14 vanced diagnostic imaging services by physi-
15 cians participating in the demonstration project
16 under this subsection against—

17 (i) the appropriateness criteria se-
18 lected under paragraph (2)(D); and
19 (ii) to the extent feasible, the utiliza-
20 tion of such services by physicians not par-
21 ticipating in the demonstration project.

22 (B) FEEDBACK REPORTS.—The Secretary
23 shall, in consultation with medical specialty so-
24 cieties and other stakeholders, develop mecha-
25 nisms to provide feedback reports to physicians

1 participating in the demonstration project
2 under this subsection. Such feedback reports
3 shall include—

4 (i) a profile of the rate of compliance
5 by the physician with appropriateness cri-
6 teria selected under paragraph (2)(D), in-
7 cluding a comparison of—

8 (I) the rate of compliance by the
9 physician with such criteria; and

10 (II) the rate of compliance by the
11 physician's peers (as defined by the
12 Secretary) with such criteria; and

13 (ii) to the extent feasible, a compari-
14 son of—

15 (I) the rate of utilization of ad-
16 vanced diagnostic imaging services by
17 the physician; and

18 (II) the rate of utilization of such
19 services by the physician's peers (as
20 defined by the Secretary) who are not
21 participating in the demonstration
22 project.

23 (4) CONDUCT OF DEMONSTRATION PROJECT

24 AND WAIVER.—

1 (A) CONDUCT OF DEMONSTRATION
2 PROJECT.—Chapter 35 of title 44, United
3 States Code, shall not apply to the conduct of
4 the demonstration project under this sub-
5 section.

6 (B) WAIVER.—The Secretary may waive
7 such provisions of titles XI and XVIII of the
8 Social Security Act (42 U.S.C. 1301 et seq.;
9 1395 et seq.) as may be necessary to carry out
10 the demonstration project under this sub-
11 section.

12 (5) EVALUATION AND REPORT.—

13 (A) EVALUATION.—The Secretary shall
14 evaluate the demonstration project under this
15 subsection to—

16 (i) assess the timeliness and efficacy
17 of the demonstration project;

18 (ii) assess the performance of entities
19 under a contract entered into under para-
20 graph (2)(I)(i);

21 (iii) analyze data—

22 (I) on the rates of appropriate,
23 uncertain, and inappropriate advanced
24 diagnostic imaging services furnished

1 by physicians participating in the
2 demonstration project;

3 (II) on patterns and trends in
4 the appropriateness and inappropri-
5 ateness of such services furnished by
6 such physicians;

7 (III) on patterns and trends in
8 national and regional variations of
9 care with respect to the furnishing of
10 such services; and

11 (IV) on the correlation between
12 the appropriateness of the services
13 furnished and image results; and
14 (iv) address—

15 (I) the thresholds used under the
16 demonstration project to identify ac-
17 ceptable and outlier levels of perform-
18 ance with respect to the appropriate-
19 ness of advanced diagnostic imaging
20 services furnished;

21 (II) whether prospective use of
22 appropriateness criteria could have an
23 effect on the volume of such services
24 furnished;

1 (III) whether expansion of the
2 use of appropriateness criteria with
3 respect to such services to a broader
4 population of Medicare beneficiaries
5 would be advisable;

6 (IV) whether, under such an ex-
7 pansion, physicians who demonstrate
8 consistent compliance with such ap-
9 propriateness criteria should be ex-
10 empted from certain requirements;

11 (V) the use of incident-specific
12 versus practice-specific outlier infor-
13 mation in formulating future rec-
14 ommendations with respect to the use
15 of appropriateness criteria for such
16 services under the Medicare program;
17 and

18 (VI) the potential for using
19 methods (including financial incen-
20 tives), in addition to those used under
21 the models under the demonstration
22 project, to ensure compliance with
23 such criteria.

24 (B) REPORT.—Not later than 1 year after
25 the completion of the demonstration project

1 under this subsection, the Secretary shall sub-
2 mit to Congress a report containing the results
3 of the evaluation of the demonstration project
4 conducted under subparagraph (A), together
5 with recommendations for such legislation and
6 administrative action as the Secretary deter-
7 mines appropriate.

8 (6) FUNDING.—The Secretary shall provide for
9 the transfer from the Federal Supplementary Med-
10 ical Insurance Trust Fund established under section
11 1841 of the Social Security Act (42 U.S.C. 1395t)
12 of \$10,000,000, for carrying out the demonstration
13 project under this subsection (including costs associ-
14 ated with administering the demonstration project,
15 reimbursing physicians for administrative costs and
16 providing incentives to encourage participation under
17 paragraph (2)(C), entering into contracts under
18 paragraph (2)(I), and evaluating the demonstration
19 project under paragraph (5)).

20 (c) GAO STUDIES AND REPORTS.—

21 (1) STUDY ON ACCREDITATION REQUIREMENT
22 FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

23 (A) STUDY.—

24 (i) IN GENERAL.—The Comptroller
25 General of the United States (in this sub-

1 section referred to as the “Comptroller
2 General”) shall conduct a study, by imag-
3 ing modality, on—

4 (I) the effect of the accreditation
5 requirement under section 1834(e) of
6 the Social Security Act, as added by
7 subsection (a); and

8 (II) any other relevant questions
9 involving access to, and the value of,
10 advanced diagnostic imaging services
11 for Medicare beneficiaries.

12 (ii) ISSUES.—The study conducted
13 under clause (i) shall examine the fol-
14 lowing:

15 (I) The impact of such accredita-
16 tion requirement on the number, type,
17 and quality of imaging services fur-
18 nished to Medicare beneficiaries.

19 (II) The cost of such accredita-
20 tion requirement, including costs to
21 facilities of compliance with such re-
22 quirement and costs to the Secretary
23 of administering such requirement.

24 (III) Access to imaging services
25 by Medicare beneficiaries, especially in

1 rural areas, before and after imple-
2 mentation of such accreditation re-
3 quirement.

4 (IV) Such other issues as the
5 Secretary determines appropriate.

6 (B) REPORTS.—

7 (i) PRELIMINARY REPORT.—Not later
8 than March 1, 2013, the Comptroller Gen-
9 eral shall submit a preliminary report to
10 Congress on the study conducted under
11 subparagraph (A).

12 (ii) FINAL REPORT.—Not later than
13 March 1, 2014, the Comptroller General
14 shall submit a final report to Congress on
15 the study conducted under subparagraph
16 (A), together with recommendations for
17 such legislation and administrative action
18 as the Comptroller General determines ap-
19 propriate.

20 (2) STUDY ON INTEREST RATE AND EQUIP-
21 MENT UTILIZATION ASSUMPTIONS USED IN DETER-
22 MINING PRACTICE EXPENSE.—

23 (A) STUDY.—

24 (i) IN GENERAL.—The Comptroller
25 General shall conduct a study on the as-

1 sumptions used for interest rate and equip-
2 ment utilization in the methodology for de-
3 termination of practice expense relative
4 value units under section 1848(c)(2)(C)(ii)
5 of the Social Security Act (42 U.S.C.
6 1395w-4(c)(2)(C)(ii)) with respect to im-
7 aging services.

8 (ii) COLLECTION OF DATA.—In con-
9 ducting the study under clause (i), the
10 Comptroller General shall collect data on
11 imaging equipment utilization for different
12 modalities of imaging equipment used in—

13 (I) different types of practices;

14 and

15 (II) different geographic areas.

16 (B) REPORT.—Not later than June 1,
17 2010, the Comptroller General shall submit to
18 Congress a report containing the results of the
19 study conducted under subparagraph (A), in-
20 cluding the data collected under clause (ii) of
21 such subparagraph, together with recommenda-
22 tions for such legislation and administrative ac-
23 tion as the Comptroller General determines ap-
24 propriate.

SEC. 136. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), and section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking “2007, and the first 6 months of 2008” and inserting “2007, 2008, and 2009”.

SEC. 137. ACCOMMODATION OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED SERVICES.

Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by section 116 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking “(before July 1, 2008)”.

SEC. 138. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule

1 under section 1848 of the Social Security Act (42
2 U.S.C. 1395w-4) during the period beginning on
3 July 1, 2008, and ending on December 31, 2009,
4 the Secretary of Health and Human Services shall
5 increase the fee schedule otherwise applicable for
6 specified services by 5 percent.

7 (2) NONAPPLICATION OF BUDGET-NEU-
8 TRALITY.—The budget-neutrality provision of sec-
9 tion 1848(c)(2)(B)(ii) of the Social Security Act (42
10 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not apply to the
11 adjustments described in paragraph (1).

12 (b) DEFINITION OF SPECIFIED SERVICES.—In this
13 section, the term “specified services” means procedure
14 codes for services in the categories of the Health Care
15 Common Procedure Coding System, established by the
16 Secretary of Health and Human Services under section
17 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w-
18 4(c)(5)), as of July 1, 2007, and as subsequently modified
19 by the Secretary, consisting of psychiatric therapeutic pro-
20 cedures furnished in office or other outpatient facility set-
21 tings or in inpatient hospital, partial hospital, or residen-
22 tial care facility settings, but only with respect to such
23 services in such categories that are in the subcategories
24 of services which are—

(1) insight oriented, behavior modifying, or supportive psychotherapy; or

(2) interactive psychotherapy.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.

SEC. 139. IMPROVEMENTS FOR MEDICARE ANESTHESIA TEACHING PROGRAMS.

(a) SPECIAL PAYMENT RULE FOR TEACHING ANESTHESIOLOGISTS.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)), as amended by section 132(b), is amended—

(1) in paragraph (4)(A), by inserting “except as provided in paragraph (5),” after “anesthesia cases,”; and

(2) by adding at the end the following new paragraph:

“(6) SPECIAL RULE FOR TEACHING ANESTHESIOLOGISTS.—With respect to physicians’ services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this sec-

tion if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

“(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

“(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.”.

(b) TREATMENT OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—With respect to items and services furnished on or after January 1, 2010, the Secretary of Health and Human Services shall make appropriate adjustments to payments under the Medicare program under title XVIII of the Social Security Act for teaching certified registered nurse anesthetists to implement a policy with respect to teaching certified registered nurse anesthetists that—

(1) is consistent with the adjustments made by the special rule for teaching anesthesiologists under section 1848(a)(6) of the Social Security Act, as added by subsection (a); and

1 (2) maintains the existing payment differences
2 between teaching anesthesiologists and teaching cer-
3 tified registered nurse anesthetists.

4 **PART II—OTHER PAYMENT AND COVERAGE**

5 **IMPROVEMENTS**

6 **SEC. 141. EXTENSION OF EXCEPTIONS PROCESS FOR MEDI-** 7 **CARE THERAPY CAPS.**

8 Section 1833(g)(5) of the Social Security Act (42
9 U.S.C. 1395l(g)(5)), as amended by section 105 of the
10 Medicare, Medicaid, and SCHIP Extension Act of 2007
11 (Public Law 110–173), is amended by striking “June 30,
12 2008” and inserting “December 31, 2009”.

13 **SEC. 142. EXTENSION OF PAYMENT RULE FOR** 14 **BRACHYTHERAPY AND THERAPEUTIC RADIO-** 15 **PHARMACEUTICALS.**

16 Section 1833(t)(16)(C) of the Social Security Act (42
17 U.S.C. 1395l(t)(16)(C)), as amended by section 106 of the
18 Medicare, Medicaid, and SCHIP Extension Act of 2007
19 (Public Law 110–173), is amended by striking “July 1,
20 2008” each place it appears and inserting “January 1,
21 2010”.

22 **SEC. 143. SPEECH-LANGUAGE PATHOLOGY SERVICES.**

23 (a) IN GENERAL.—Section 1861(ll) of the Social Se-
24 curity Act (42 U.S.C. 1395x(ll)) is amended—

1 (1) by redesignating paragraphs (2) and (3) as
2 paragraphs (3) and (4), respectively; and

3 (2) by inserting after paragraph (1) the fol-
4 lowing new paragraph:

5 “(2) The term ‘outpatient speech-language pathology
6 services’ has the meaning given the term ‘outpatient phys-
7 ical therapy services’ in subsection (p), except that in ap-
8 plying such subsection—

9 “(A) ‘speech-language pathology’ shall be sub-
10 stituted for ‘physical therapy’ each place it appears;
11 and

12 “(B) ‘speech-language pathologist’ shall be sub-
13 stituted for ‘physical therapist’ each place it ap-
14 pears.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) Section 1832(a)(2)(C) of the Social Security
17 Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

18 (A) by striking “and outpatient” and in-
19 serting “, outpatient”; and

20 (B) by inserting before the semicolon at
21 the end the following: “, and outpatient speech-
22 language pathology services (other than services
23 to which the second sentence of section 1861(p)
24 applies through the application of section
25 1861(l)(2))”.

(2) Subparagraphs (A) and (B) of section 1833(a)(8) of the Social Security Act (42 U.S.C. 1395l(a)(8)) are each amended by striking “(which includes outpatient speech-language pathology services)” and inserting “, outpatient speech-language pathology services,”.

(3) Section 1833(g)(1) of the Social Security Act (42 U.S.C. 1395l(g)(1)) is amended—

(A) by inserting “and speech-language pathology services of the type described in such section through the application of section 1861(l)(2)” after “1861(p)”; and

(B) by inserting “and speech-language pathology services” after “and physical therapy services”.

(4) The second sentence of section 1835(a) of the Social Security Act (42 U.S.C. 1395n(a)) is amended—

(A) by striking “section 1861(g)” and inserting “subsection (g) or (l)(2) of section 1861” each place it appears; and

(B) by inserting “or outpatient speech-language pathology services, respectively” after “occupational therapy services”.

1 (5) Section 1861(p) of the Social Security Act
2 (42 U.S.C. 1395x(p)) is amended by striking the
3 fourth sentence.

4 (6) Section 1861(s)(2)(D) of the Social Secu-
5 rity Act (42 U.S.C. 1395x(s)(2)(D)) is amended by
6 inserting “, outpatient speech-language pathology
7 services,” after “physical therapy services”.

8 (7) Section 1862(a)(20) of the Social Security
9 Act (42 U.S.C. 1395y(a)(20)) is amended—

10 (A) by striking “outpatient occupational
11 therapy services or outpatient physical therapy
12 services” and inserting “outpatient physical
13 therapy services, outpatient speech-language pa-
14 thology services, or outpatient occupational
15 therapy services”; and

16 (B) by striking “section 1861(g)” and in-
17 serting “subsection (g) or (ll)(2) of section
18 1861”.

19 (8) Section 1866(e)(1) of the Social Security
20 Act (42 U.S.C. 1395cc(e)(1)) is amended—

21 (A) by striking “section 1861(g)” and in-
22 serting “subsection (g) or (ll)(2) of section
23 1861” the first two places it appears;

24 (B) by striking “defined) or” and inserting
25 “defined),”; and

(C) by inserting before the semicolon at the end the following: “, or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology”.

(9) Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following new subparagraph:

“(L) Outpatient speech-language pathology services.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after July 1, 2009.

(d) CONSTRUCTION.—Nothing in this section shall be construed to affect existing regulations and policies of the Centers for Medicare & Medicaid Services that require physician oversight of care as a condition of payment for speech-language pathology services under part B of the Medicare program.

SEC. 144. PAYMENT AND COVERAGE IMPROVEMENTS FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND OTHER CONDITIONS.

(a) COVERAGE OF PULMONARY AND CARDIAC REHABILITATION.—

1 (1) IN GENERAL.—Section 1861 of the Social
 2 Security Act (42 U.S.C. 1395x), as amended by sec-
 3 tion 101(a), is amended—

4 (A) in subsection (s)(2)—

5 (i) in subparagraph (AA), by striking
 6 “and” at the end;

7 (ii) in subparagraph (BB), by adding
 8 “and” after the semicolon at the end; and

9 (iii) by adding at the end the fol-
 10 lowing new subparagraph:

11 “(CC) items and services furnished under
 12 a cardiac rehabilitation program (as defined in
 13 subsection (eee)(1)) or under a pulmonary reha-
 14 bilitation program (as defined in subsection
 15 (fff)(1));” and

16 (B) by adding at the end the following new
 17 subsections:

18 “Cardiac Rehabilitation Program

19 “(eee)(1) The term ‘cardiac rehabilitation program’
 20 means a physician-supervised program (as described in
 21 paragraph (2)) that furnishes the items and services de-
 22 scribed in paragraph (3).

23 “(2) A program described in this paragraph is a pro-
 24 gram under which—

1 “(A) items and services under the program are
2 delivered—

3 “(i) in a physician’s office;

4 “(ii) in a hospital on an outpatient basis;

5 or

6 “(iii) in other settings determined appro-
7 priate by the Secretary.

8 “(B) a physician is immediately available and
9 accessible for medical consultation and medical
10 emergencies at all times items and services are being
11 furnished under the program, except that, in the
12 case of items and services furnished under such a
13 program in a hospital, such availability shall be pre-
14 sumed; and

15 “(C) individualized treatment is furnished
16 under a written plan established, reviewed, and
17 signed by a physician every 30 days that describes—

18 “(i) the individual’s diagnosis;

19 “(ii) the type, amount, frequency, and du-
20 ration of the items and services furnished under
21 the plan; and

22 “(iii) the goals set for the individual under
23 the plan.

24 “(3) The items and services described in this para-
25 graph are—

1 “(A) physician-prescribed exercise;

2 “(B) cardiac risk factor modification, including
3 education, counseling, and behavioral intervention
4 (to the extent such education, counseling, and behav-
5 ioral intervention is closely related to the individual’s
6 care and treatment and is tailored to the individual’s
7 needs);

8 “(C) psychosocial assessment;

9 “(D) outcomes assessment; and

10 “(E) such other items and services as the Sec-
11 retary may determine, but only if such items and
12 services are—

13 “(i) reasonable and necessary for the diag-
14 nosis or active treatment of the individual’s
15 condition;

16 “(ii) reasonably expected to improve or
17 maintain the individual’s condition and func-
18 tional level; and

19 “(iii) furnished under such guidelines re-
20 lating to the frequency and duration of such
21 items and services as the Secretary shall estab-
22 lish, taking into account accepted norms of
23 medical practice and the reasonable expectation
24 of improvement of the individual.

1 “(4) The Secretary shall establish standards to en-
2 sure that a physician with expertise in the management
3 of individuals with cardiac pathophysiology who is licensed
4 to practice medicine in the State in which a cardiac reha-
5 bilitation program (or the intensive cardiac rehabilitation
6 program, as the case may be) is offered—

7 “(A) is responsible for such program; and

8 “(B) in consultation with appropriate staff, is
9 involved substantially in directing the progress of in-
10 dividual in the program.

11 “Pulmonary Rehabilitation Program

12 “(fff)(1) The term ‘pulmonary rehabilitation pro-
13 gram’ means a physician-supervised program (as de-
14 scribed in subsection (eee)(2) with respect to a program
15 under this subsection) that furnishes the items and serv-
16 ices described in paragraph (2).

17 “(2) The items and services described in this para-
18 graph are—

19 “(A) physician-prescribed exercise;

20 “(B) education or training (to the extent the
21 education or training is closely and clearly related to
22 the individual’s care and treatment and is tailored to
23 such individual’s needs);

24 “(C) psychosocial assessment;

25 “(D) outcomes assessment; and

1 “(E) such other items and services as the Sec-
2 retary may determine, but only if such items and
3 services are—

4 “(i) reasonable and necessary for the diag-
5 nosis or active treatment of the individual’s
6 condition;

7 “(ii) reasonably expected to improve or
8 maintain the individual’s condition and func-
9 tional level; and

10 “(iii) furnished under such guidelines re-
11 lating to the frequency and duration of such
12 items and services as the Secretary shall estab-
13 lish, taking into account accepted norms of
14 medical practice and the reasonable expectation
15 of improvement of the individual.

16 “(3) The Secretary shall establish standards to en-
17 sure that a physician with expertise in the management
18 of individuals with respiratory pathophysiology who is li-
19 censed to practice medicine in the State in which a pul-
20 monary rehabilitation program is offered—

21 “(A) is responsible for such program; and

22 “(B) in consultation with appropriate staff, is
23 involved substantially in directing the progress of in-
24 dividual in the program.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

(b) REPEAL OF TRANSFER OF OWNERSHIP OF OXY-
GEN EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(A) in the heading, by striking “OWNER-
SHIP OF EQUIPMENT” and inserting “RENTAL
CAP”; and

(B) by striking clause (ii) and inserting the
following:

“(ii) PAYMENTS AND RULES AFTER
RENTAL CAP.—After the 36th continuous
month during which payment is made for
the equipment under this paragraph—

“(I) the supplier furnishing such
equipment under this subsection shall
continue to furnish the equipment
during any period of medical need for
the remainder of the reasonable useful
lifetime of the equipment, as deter-
mined by the Secretary;

1 “(II) payments for oxygen shall
2 continue to be made in the amount
3 recognized for oxygen under para-
4 graph (9) for the period of medical
5 need; and

6 “(III) maintenance and servicing
7 payments shall, if the Secretary deter-
8 mines such payments are reasonable
9 and necessary, be made (for parts and
10 labor not covered by the supplier’s or
11 manufacturer’s warranty, as deter-
12 mined by the Secretary to be appro-
13 priate for the equipment), and such
14 payments shall be in an amount deter-
15 mined to be appropriate by the Sec-
16 retary.”.

17 (2) EFFECTIVE DATE.—The amendments made
18 by paragraph (1) shall take effect on January 1,
19 2009.

20 (c) REVISION OF PAYMENT FOR OXYGEN AND OXY-
21 GEN EQUIPMENT, PORTABLE OXYGEN EQUIPMENT, AND
22 OXYGEN FOR STATIONARY EQUIPMENT.—

23 (1) SEPARATE PAYMENT FOR OXYGEN EQUIP-
24 MENT AND OXYGEN FOR STATIONARY EQUIPMENT.—
25 Section 1834(a) of the Social Security Act (42

1 U.S.C. 1395m(a)) is amended by adding at the end
2 the following new paragraph:

3 “(22) ADDITIONAL SPECIAL PAYMENT RULE
4 BEGINNING IN 2009.—

5 “(A) IN GENERAL.—Notwithstanding the
6 preceding provisions of this subsection, for oxy-
7 gen equipment (other than portable oxygen and
8 oxygen equipment) furnished during 2009, the
9 payment amount otherwise determined under
10 this subsection for such equipment shall be
11 equal to—

12 “(i) the amount of the monthly pay-
13 ment amount otherwise established by the
14 Secretary under this subsection for oxygen
15 and oxygen equipment (other than portable
16 oxygen equipment) furnished in 2009;
17 minus

18 “(ii) 71 percent of the amount of the
19 monthly payment amount established by
20 the Secretary under this subsection for ox-
21 ygen for stationary equipment furnished in
22 such year.

23 “(B) APPLICATION OF UPDATE TO SPE-
24 CIAL PAYMENT AMOUNT.—The covered item up-
25 date under paragraph (14) for oxygen equip-

1 ment for 2010 and each subsequent year shall
2 be applied to the payment amount under sub-
3 paragraph (A) unless payment is made for such
4 items and supplies under section 1847.”.

5 (2) ADD-ON PAYMENT FOR OXYGEN FOR STA-
6 TIONARY OXYGEN EQUIPMENT.—Section 1834(a)(5)
7 of the Social Security Act (42 U.S.C. 1395m(a)(5))
8 is amended by adding at the end the following new
9 subparagraph:

10 “(G) ADD-ON FOR OXYGEN FOR STA-
11 TIONARY OXYGEN EQUIPMENT.—In the case of
12 oxygen furnished on or after January 1, 2009,
13 when oxygen is used with stationary oxygen
14 equipment, the payment amount recognized
15 under subparagraph (A) shall be increased by
16 the amount established by the Secretary for
17 such oxygen (or 71 percent of such amount
18 during the rental period for such equipment).”.

19 (3) EQUALIZING ADD-ON PAYMENT FOR OXY-
20 GEN FOR PORTABLE OXYGEN AND OXYGEN EQUIP-
21 MENT DURING MONTHLY RENTAL PERIOD AND PAY-
22 MENT FOR SUCH OXYGEN AND OXYGEN EQUIPMENT
23 AFTER SUCH RENTAL PERIOD.—Section 1834(a)(9)
24 of the Social Security Act (42 U.S.C. 1395m(a)(9))

1 is amended by adding at the end the following new
2 subparagraph:

3 “(E) SPECIAL RULE FOR ADD-ON PAY-
4 MENT FOR PORTABLE OXYGEN AND OXYGEN
5 EQUIPMENT.—In the case of oxygen and oxygen
6 equipment furnished on or after January 1,
7 2009, for purposes of paragraph (5)(B), the
8 monthly amount recognized under this para-
9 graph for portable oxygen and oxygen equip-
10 ment in a year shall be equal to the monthly
11 payment amount for portable oxygen and oxy-
12 gen equipment applicable for the year under
13 this subsection after the end of the 36-month
14 period under paragraph (5)(F).”.

15 (4) SPECIAL RULE FOR ADD-ON PAYMENTS FOR
16 OXYGEN GENERATING PORTABLE EQUIPMENT.—Sec-
17 tion 1834(a)(9) of the Social Security Act (42
18 U.S.C. 1395m(a)(9)), as amended by paragraph (3),
19 is amended by adding at the end the following new
20 subparagraph:

21 “(F) SPECIAL RULE FOR ADD-ON PAY-
22 MENT FOR OXYGEN GENERATING PORTABLE
23 EQUIPMENT.—In the case of oxygen generating
24 portable equipment, as defined by the Sec-
25 retary, furnished on or after January 1, 2009,

1 the Secretary shall make the following monthly
2 add-on payments during the 36-month rental
3 period under paragraph (5)(F):

4 “(i) An amount equal to the monthly
5 payment amount specified in subparagraph
6 (E) for the month.

7 “(ii) An amount equal to the monthly
8 payment amount otherwise established by
9 the Secretary under this subsection for
10 such equipment for the month that recog-
11 nizes that such equipment substitutes for
12 the delivery of portable oxygen and oxygen
13 contents during the remaining useful life of
14 the equipment that occurs after the end of
15 such 36-month rental period.”.

16 (5) CAP ON TOTAL MONTHLY PAYMENT FOR
17 LIQUID OR GASEOUS STATIONARY AND PORTABLE
18 SYSTEMS.—Section 1834(a)(5) of the Social Security
19 Act (42 U.S.C. 1395m(a)(5)), as amended by para-
20 graph (2), is amended by adding at the end the fol-
21 lowing new subparagraph:

22 “(H) CAP ON TOTAL PAYMENTS FOR LIQ-
23 UID OR GASEOUS STATIONARY AND PORTABLE
24 SYSTEMS.—In the case of a liquid or gaseous
25 stationary and portable system furnished on or

1 after January 1, 2009, the total monthly
2 amount recognized under this part for such sys-
3 tem for a month (including any add-on pay-
4 ments under this subsection) may not exceed
5 the total monthly amount that would have oth-
6 erwise been recognized under this part for such
7 system for the month (including any add-on
8 payments under this subsection) if the amend-
9 ments made by section 144(c) of the Medicare
10 Efficiency and Development of Improvement of
11 Care and Services Act (MEDICS Act) of 2008
12 had not been enacted.”.

13 (6) CONFORMING AMENDMENTS.—(A) Section
14 1834(a)(5)(A) of the Social Security Act (42 U.S.C.
15 1395m(a)(5)(A)) is amended—

16 (i) by inserting “and, in the case of items
17 and services furnished on or after January 1,
18 2009, other than oxygen for stationary equip-
19 ment” after “portable oxygen equipment”; and

20 (ii) by striking “subparagraphs (B), (C),
21 (E), and (F)” and inserting “the succeeding
22 provisions of this paragraph”.

23 (B) Section 1834(a)(9) of the Social Security
24 Act (42 U.S.C. 1395m(a)(9)) is amended—

1 (i) in the first sentence of the matter pre-
2 ceding subparagraph (A), by striking “For pur-
3 poses” and inserting “Subject to paragraphs
4 (21) and (22), for purposes”; and

5 (ii) in the second sentence of the matter
6 preceding subparagraph (A)—

7 (I) by inserting “and, in the case of
8 items and services furnished on or after
9 January 1, 2009, other than oxygen for
10 stationary equipment” after “portable oxy-
11 gen equipment”;

12 (II) by striking “and” before “(ii)”
13 and inserting a comma; and

14 (III) by inserting “, and (iii) in the
15 case of items and services furnished on or
16 after January 1, 2009, for oxygen for sta-
17 tionary equipment” before “(each such
18 group”.

19 (d) APPLICATION TO COMPETITIVE BIDDING.—The
20 amendments made by subsections (b) and (c) shall not
21 apply to contracts entered into under section 1847 of the
22 Social Security Act (42 U.S.C. 1395w–3) prior to Sep-
23 tember 1, 2008, pursuant to the implementation of sub-
24 section (a)(1)(B)(i)(I) of such section 1847.

1 (e) INSTITUTE OF MEDICINE STUDY AND REPORT
2 ON PAYMENTS FOR DIFFERENT CLASSES OF OXYGEN
3 EQUIPMENT.—

4 (1) STUDY.—Not later than 3 months after the
5 date of the enactment of this Act, the Secretary of
6 Health and Human Services shall enter into a con-
7 tract with the Institute of Medicine of the National
8 Academies (in this section referred to as the “Insti-
9 tute”) under which the Institute shall conduct a
10 study on the furnishing of, and payments for, oxy-
11 gen and oxygen equipment under the Medicare pro-
12 gram. Such study shall include an analysis of the
13 following:

14 (A) The costs and activities associated with
15 furnishing different modalities of oxygen equip-
16 ment (covering gaseous and liquid portable
17 equipment and oxygen generating portable
18 equipment), including—

19 (i) the acquisition cost of the oxygen
20 equipment;

21 (ii) the delivery and refilling of oxygen
22 contents for stationary and portable sys-
23 tems, including the frequency of delivery;

24 (iii) the delivery of the equipment and
25 the provision of supplies and accessories;

1 (iv) training and education, intake of
2 patient information and related docu-
3 mentation, and responding to beneficiary
4 inquiries;

5 (v) servicing of different types of oxy-
6 gen and oxygen equipment, including—

7 (I) the type and frequency of
8 routine and nonroutine servicing fur-
9 nished, and variation across suppliers
10 in furnishing such servicing; and

11 (II) the extent to which emer-
12 gency or after hours servicing is need-
13 ed and furnished; and

14 (vi) other items or activities involved
15 with furnishing oxygen and oxygen equip-
16 ment not described in clauses (i) though
17 (v).

18 (B) Whether the various items and activi-
19 ties described in subparagraph (A) are medi-
20 cally necessary and affect patient outcomes.

21 (C)(i) The adequacy of Medicare payment
22 rates for oxygen equipment and necessary serv-
23 icing and items and activities furnished in con-
24 nection with the provision of oxygen and oxygen
25 equipment; and

(ii) how such payment rates compare to competitively bid rates.

(D) Whether payment rates for oxygen and oxygen equipment under the Medicare program should vary depending on the modality of oxygen equipment used or should be the same for all modalities.

(E) The adequacy of add-on payments under the Medicare program for—

(i) contents for stationary equipment;

(ii) contents for portable equipment;

and

(iii) oxygen-generating portable equipment.

(F)(i) Whether, during the rental period for oxygen equipment under the Medicare program, payment for such equipment and servicing should be bundled together or whether separate payments are appropriate; and

(ii) if separate payments are appropriate, how the payment should be allocated between equipment and servicing.

(G) Options that could be considered for suppliers to document or report under the Medicare program detailed information on ac-

1 activities related to furnishing oxygen and oxygen
2 equipment to Medicare beneficiaries.

3 (2) SURVEY.—In conducting the study under
4 paragraph (1), the Institute shall conduct a survey
5 of suppliers of oxygen and oxygen equipment to ob-
6 tain data on items described in paragraph (1)(A).

7 (3) REPORT.—Not later than 18 months after
8 the date of the enactment of this Act, the Institute
9 shall submit to the Secretary of Health and Human
10 Services a report containing the results of the study
11 conducted under paragraph (1), together with such
12 recommendations as the Institute determines appro-
13 priate.

14 (4) FUNDING.—For the purpose of carrying out
15 this section, the Secretary of Health and Human
16 Services shall provide for the transfer, from the Fed-
17 eral Supplementary Medical Insurance Trust Fund
18 established under section 1841 of the Social Security
19 Act (42 U.S.C. 1395t), of \$5,000,000 to the Centers
20 for Medicare & Medicaid Services Program Manage-
21 ment Account.

1 **SEC. 145. REVISION OF PAYMENT FOR POWER-DRIVEN**
2 **WHEELCHAIRS.**

3 (a) **IN GENERAL.**—Section 1834(a)(7)(A) of the So-
4 cial Security Act (42 U.S.C. 1395m(a)(7)(A)) is amend-
5 ed—

6 (1) in clause (i)—

7 (A) in subclause (II), by inserting “sub-
8 clause (III) and” after “Subject to”; and

9 (B) by adding at the end the following new
10 subclause:

11 “(III) **SPECIAL RULE FOR**
12 **POWER-DRIVEN WHEELCHAIRS.**—For
13 purposes of payment for power-driven
14 wheelchairs, subclause (II) shall be
15 applied by substituting ‘15 percent’
16 and ‘6 percent’ for ‘10 percent’ and
17 ‘7.5 percent’, respectively.”; and

18 (2) in clause (iii)—

19 (A) in the heading, by inserting “COM-
20 PLEX, REHABILITATIVE” before “POWER-DRIV-
21 EN”; and

22 (B) by inserting “complex, rehabilitative”
23 before “power-driven”.

24 (b) **TECHNICAL AMENDMENT.**—Section
25 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C.

1 1395m(a)(7)(C)(ii)(II)) is amended by striking “(A)(ii)
2 or”.

3 (c) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Subject to paragraph (2),
5 the amendments made by subsection (a) shall take
6 effect on January 1, 2009, and shall apply to power-
7 driven wheelchairs furnished on or after such date.

8 (2) APPLICATION TO COMPETITIVE BIDDING.—

9 The amendments made by subsection (a) shall not
10 apply to contracts entered into under section 1847
11 of the Social Security Act (42 U.S.C. 1395w-3)
12 prior to January 1, 2009, pursuant to the implemen-
13 tation of subsection (a)(1)(B)(i)(I) of such section
14 1847.

15 **SEC. 146. CLINICAL LABORATORY TESTS.**

16 (a) REPEAL OF MEDICARE COMPETITIVE BIDDING
17 DEMONSTRATION PROJECT FOR CLINICAL LABORATORY
18 SERVICES.—

19 (1) IN GENERAL.—Section 1847 of the Social
20 Security Act (42 U.S.C. 1395w-3) is amended by
21 striking subsection (e).

22 (2) CONFORMING AMENDMENTS.—Section
23 1833(a)(1)(D) of the Social Security Act (42 U.S.C.
24 1395l(a)(1)(D)) is amended—

25 (A) by inserting “or” before “(ii)”; and

1 (B) by striking “or (iii) on the basis” and
2 all that follows before the comma at the end.

3 (3) EFFECTIVE DATE.—The amendments made
4 by this subsection shall take effect on the date of the
5 enactment of this Act.

6 (b) CLINICAL LABORATORY TEST FEE SCHEDULE
7 UPDATE ADJUSTMENT.—Section 1833(h)(2)(A)(i) of the
8 Social Security Act (42 U.S.C. 1395l(h)(2)(A)(ii)) is
9 amended by inserting “minus, for each of the years 2009
10 through 2013, 0.5 percentage points” after “city aver-
11 age)”.

12 **SEC. 147. IMPROVED ACCESS TO AMBULANCE SERVICES.**

13 (a) EXTENSION OF INCREASED MEDICARE PAY-
14 MENTS FOR GROUND AMBULANCE SERVICES.—Section
15 1834(l)(13) of the Social Security Act (42 U.S.C.
16 1395m(l)(13)) is amended—

17 (1) in subparagraph (A)—

18 (A) in the matter preceding clause (i), by
19 inserting “and for such services furnished on or
20 after July 1, 2008, and before January 1,
21 2010” after “2007,”;

22 (B) in clause (i), by inserting “(or 3 per-
23 cent if such service is furnished on or after July
24 1, 2008, and before January 1, 2010)” after “2
25 percent”; and

1 (C) in clause (ii), by inserting “(or 2 per-
2 cent if such service is furnished on or after July
3 1, 2008, and before January 1, 2010)” after “1
4 percent”; and

5 (2) in subparagraph (B)—

6 (A) in the heading, by striking “2006” and
7 inserting “APPLICABLE PERIOD”; and

8 (B) by inserting “applicable” before “pe-
9 riod”.

10 (b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

11 (1) TREATMENT OF CERTAIN AREAS FOR PAY-
12 MENT FOR AIR AMBULANCE SERVICES UNDER THE
13 AMBULANCE FEE SCHEDULE.—Notwithstanding any
14 other provision of law, for purposes of making pay-
15 ments under section 1834(l) of the Social Security
16 Act (42 U.S.C. 1395m(l)) for air ambulance services
17 furnished during the period beginning on July 1,
18 2008, and ending on December 31, 2009, any area
19 that was designated as a rural area for purposes of
20 making payments under such section for air ambu-
21 lance services furnished on December 31, 2006, shall
22 be treated as a rural area for purposes of making
23 payments under such section for air ambulance serv-
24 ices furnished during such period.

(2) CLARIFICATION REGARDING SATISFACTION
OF REQUIREMENT OF MEDICALLY NECESSARY.—

(A) IN GENERAL.—Section
1834(l)(14)(B)(i) of the Social Security Act (42
U.S.C. 1395m(l)(14)(B)(i)) is amended by
striking “reasonably determines or certifies”
and inserting “certifies or reasonably deter-
mines”.

(B) EFFECTIVE DATE.—The amendment
made by subparagraph (A) shall apply to serv-
ices furnished on or after the date of the enact-
ment of this Act.

**SEC. 148. EXTENSION AND EXPANSION OF THE MEDICARE
HOLD HARMLESS PROVISION UNDER THE
PROSPECTIVE PAYMENT SYSTEM FOR HOS-
PITAL OUTPATIENT DEPARTMENT (HOPD)
SERVICES FOR CERTAIN HOSPITALS.**

Section 1833(t)(7)(D)(i) of the Social Security Act
(42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking
“2009” and inserting “2010”; and

(B) by striking the second sentence and in-
serting the following new sentence: “For pur-
poses of the preceding sentence, the applicable

1 percentage shall be 95 percent with respect to
 2 covered OPD services furnished in 2006, 90
 3 percent with respect to such services furnished
 4 in 2007, and 85 percent with respect to such
 5 services furnished in 2008 or 2009.”; and

6 (2) by adding at the end the following new sub-
 7 clause:

8 “(III) In the case of a sole community
 9 hospital (as defined in section
 10 1886(d)(5)(D)(iii)) that has not more than
 11 100 beds, for covered OPD services fur-
 12 nished on or after January 1, 2009, and
 13 before January 1, 2010, for which the
 14 PPS amount is less than the pre-BBA
 15 amount, the amount of payment under this
 16 subsection shall be increased by 85 percent
 17 of the amount of such difference.”.

18 **SEC. 149. CLARIFICATION OF PAYMENT FOR CLINICAL LAB-**
 19 **ORATORY TESTS FURNISHED BY CRITICAL**
 20 **ACCESS HOSPITALS.**

21 (a) IN GENERAL.—Section 1834(g)(4) of the Social
 22 Security Act (42 U.S.C. 1395m(g)(4)) is amended—

23 (1) in the heading, by striking “NO BENE-
 24 FICIARY COST-SHARING FOR” and inserting “TREAT-
 25 MENT OF”; and

(2) by adding at the end the following new sentence: “For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to services furnished on or after July 1, 2009.

SEC. 150. ADDING CERTAIN ENTITIES AS ORIGINATING SITES FOR PAYMENT OF TELEHEALTH SERVICES.

(a) **IN GENERAL.**—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

“(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

1 “(VII) A skilled nursing facility
2 (as defined in section 1819(a)).

3 “(VIII) A community mental
4 health center (as defined in section
5 1861(ff)(3)(B)).”.

6 (b) CONFORMING AMENDMENT.—Section
7 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C.
8 1395yy(e)(2)(A)(ii)) is amended by inserting “telehealth
9 services furnished under section 1834(m)(4)(C)(ii)(VII),”
10 after “section 1861(s)(2),”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to services furnished on or after
13 January 1, 2009.

14 **SEC. 151. MEDPAC STUDY AND REPORT ON IMPROVING**
15 **CHRONIC CARE DEMONSTRATION PRO-**
16 **GRAMS.**

17 (a) STUDY.—The Medicare Payment Advisory Com-
18 mission shall conduct a study on the feasibility and advis-
19 ability of establishing a Medicare Chronic Care Practice
20 Research Network that would serve as a standing network
21 of providers testing new models of care coordination and
22 other care approaches for chronically ill beneficiaries, in-
23 cluding the initiation, operation, evaluation, and, if appro-
24 priate, expansion of such models to the broader Medicare
25 patient population.

1 (b) REPORT.—Not later than June 15, 2009, the
2 Medicare Payment Advisory Commission shall submit to
3 Congress a report containing the results of the study con-
4 ducted under subsection (a).

5 **SEC. 152. INCREASE OF FQHC PAYMENT LIMITS.**

6 (a) IN GENERAL.—Section 1833 of the Social Secu-
7 rity Act (42 U.S.C. 1395l), as amended by section 133(a),
8 is amended by adding at the end the following new sub-
9 section:

10 “(w) INCREASE OF FQHC PAYMENT LIMITS.—In the
11 case of services furnished by federally qualified health cen-
12 ters (as defined in section 1861(aa)(4)), the Secretary
13 shall establish payment limits with respect to such services
14 under this part for services furnished—

15 “(1) in 2010, at the limits otherwise established
16 under this part for such year increased by \$5; and

17 “(2) in a subsequent year, at the limits estab-
18 lished under this subsection for the previous year in-
19 creased by the percentage increase in the MEI (as
20 defined in section 1842(i)(3)) for such subsequent
21 year.”.

22 (b) STUDY AND REPORT ON THE EFFECTS AND ADE-
23 QUACY OF THE MEDICARE FEDERALLY QUALIFIED
24 HEALTH CENTER PAYMENT STRUCTURE.—

1 (1) STUDY.—The Comptroller General of the
2 United States shall conduct a study to determine
3 whether the structure for payments for services fur-
4 nished by federally qualified health centers (as de-
5 fined in section 1861(aa)(4) of the Social Security
6 Act (42 U.S.C. 1395x(aa)(4)) under part B of title
7 XVIII of the Social Security Act (42 U.S.C. 1395j
8 et seq.) adequately reimburses federally qualified
9 health centers for the care furnished to Medicare
10 beneficiaries. In conducting such study, the Comp-
11 troller General shall—

12 (A) use the most current cost report data
13 available;

14 (B) examine the effects of the payment
15 limits established with respect to such services
16 under such part B on the ability of federally
17 qualified health centers to furnish care to Medi-
18 care beneficiaries; and

19 (C) examine the cost of furnishing services
20 covered under the Medicare program as of the
21 date of the enactment of this Act that were not
22 covered under such program as of the date on
23 which the Secretary determined the payment
24 rate for federally qualified health centers in
25 1991.

(2) REPORT.—Not later than 15 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action the Comptroller General determines appropriate, taking into consideration the structure and adequacy of the prospective payment methodology used to make payments to federally qualified health centers under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 153. KIDNEY DISEASE EDUCATION AND AWARENESS PROVISIONS.

(a) CHRONIC KIDNEY DISEASE INITIATIVES.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

“SEC. 399R. CHRONIC KIDNEY DISEASE INITIATIVES.

“(a) IN GENERAL.—The Secretary shall establish pilot projects to—

“(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) regarding chronic kidney disease, focusing on prevention;

1 “(2) increase screening for chronic kidney dis-
2 ease, focusing on Medicare beneficiaries at risk of
3 chronic kidney disease; and

4 “(3) enhance surveillance systems to better as-
5 sess the prevalence and incidence of chronic kidney
6 disease.

7 “(b) SCOPE AND DURATION.—

8 “(1) SCOPE.—The Secretary shall select at
9 least 3 States in which to conduct pilot projects
10 under this section.

11 “(2) DURATION.—The pilot projects under this
12 section shall be conducted for a period that is not
13 longer than 5 years and shall begin on January 1,
14 2009.

15 “(c) EVALUATION AND REPORT.—The Comptroller
16 General of the United States shall conduct an evaluation
17 of the pilot projects conducted under this section. Not
18 later than 12 months after the date on which the pilot
19 projects are completed, the Comptroller General shall sub-
20 mit to Congress a report on the evaluation.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated such sums as may be
23 necessary for the purpose of carrying out this section.”.

24 (b) MEDICARE COVERAGE OF KIDNEY DISEASE PA-
25 TIENT EDUCATION SERVICES.—

(1) COVERAGE OF KIDNEY DISEASE EDUCATION
SERVICES.—

(A) COVERAGE.—Section 1861(s)(2) of the
Social Security Act (42 U.S.C. 1395x(s)(2)), as
amended by section 144(a), is amended—

(i) in subparagraph (BB), by striking
“and” after the semicolon at the end;

(ii) in subparagraph (CC), by adding
“and” after the semicolon at the end; and

(iii) by adding at the end the fol-
lowing new subparagraph:

“(DD) kidney disease education services (as de-
fined in subsection (ggg));”.

(B) SERVICES DESCRIBED.—Section 1861
of the Social Security Act (42 U.S.C. 1395x),
as amended by section 144(a), is amended by
adding at the end the following new subsection:

“Kidney Disease Education Services

“(ggg)(1) The term ‘kidney disease education serv-
ices’ means educational services that are—

“(A) furnished to an individual with stage IV
chronic kidney disease who, according to accepted
clinical guidelines identified by the Secretary, will re-
quire dialysis or a kidney transplant;

1 “(B) furnished, upon the referral of the physi-
2 cian managing the individual’s kidney condition, by
3 a qualified person (as defined in paragraph (2)); and

4 “(C) designed—

5 “(i) to provide comprehensive information
6 (consistent with the standards set under para-
7 graph (3)) regarding—

8 “(I) the management of comorbidities,
9 including for purposes of delaying the need
10 for dialysis;

11 “(II) the prevention of uremic com-
12 plications; and

13 “(III) each option for renal replace-
14 ment therapy (including hemodialysis and
15 peritoneal dialysis at home and in-center
16 as well as vascular access options and
17 transplantation);

18 “(ii) to ensure that the individual has the
19 opportunity to actively participate in the choice
20 of therapy; and

21 “(iii) to be tailored to meet the needs of
22 the individual involved.

23 “(2)(A) The term ‘qualified person’ means—

24 “(i) a physician (as defined in section
25 1861(r)(1)) or a physician assistant, nurse practi-

tioner, or clinical nurse specialist (as defined in section 1861(aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1848; and

“(ii) a provider of services located in a rural area (as defined in section 1886(d)(2)(D)).

“(B) Such term does not include a provider of services (other than a provider of services described in subparagraph (A)(ii)) or a renal dialysis facility.

“(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

“(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this title.”.

1 (C) PAYMENT UNDER THE PHYSICIAN FEE
2 SCHEDULE.—Section 1848(j)(3) of the Social
3 Security Act (42 U.S.C. 1395w-4(j)(3)), is
4 amended by inserting “(2)(DD),” after
5 “(2)(AA),”.

6 (D) LIMITATION ON NUMBER OF SES-
7 SIONS.—Section 1862(a)(1) of the Social Secu-
8 rity Act (42 U.S.C. 1395y(a)(1)) is amended—

9 (i) in subparagraph (M), by striking
10 “and” at the end;

11 (ii) in subparagraph (N), by striking
12 the semicolon at the end and inserting “,
13 and”; and

14 (iii) by adding at the end the fol-
15 lowing new subparagraph:

16 “(O) in the case of kidney disease education
17 services (as defined in paragraph (1) of section
18 1861(ggg)), which are furnished in excess of the
19 number of sessions covered under paragraph (4) of
20 such section;”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by this subsection shall apply to services furnished
23 on or after January 1, 2010.

24 **SEC. 154. RENAL DIALYSIS PROVISIONS.**

25 (a) COMPOSITE RATE.—

1 (1) UPDATE.—Section 1881(b)(12)(G) of the
2 Social Security Act (42 U.S.C. 1395rr(b)(12)(G)) is
3 amended—

4 (A) in clause (i), by striking “and” at the
5 end;

6 (B) in clause (ii)—

7 (i) by inserting “and before January
8 1, 2009,” after “April 1, 2007,”; and

9 (ii) by striking the period at the end
10 and inserting a semicolon; and

11 (C) by adding at the end the following new
12 clauses:

13 “(iii) furnished on or after January 1, 2009,
14 and before January 1, 2010, by 1.0 percent above
15 the amount of such composite rate component for
16 such services furnished on December 31, 2008; and

17 “(iv) furnished on or after January 1, 2010, by
18 1.0 percent above the amount of such composite rate
19 component for such services furnished on December
20 31, 2009.”.

21 (2) SITE NEUTRAL COMPOSITE RATE.—Section
22 1881(b)(12)(A) of the Social Security Act (42
23 U.S.C. 1395rr(b)(12)(A)) is amended by adding at
24 the end the following new sentence: “Under such
25 system, the payment rate for dialysis services fur-

1 nished on or after January 1, 2009, by providers of
2 services shall be the same as the payment rate (com-
3 puted without regard to this sentence) for such serv-
4 ices furnished by renal dialysis facilities, and in ap-
5 plying the geographic index under subparagraph (D)
6 to providers of services, the labor share shall be
7 based on the labor share otherwise applied for renal
8 dialysis facilities.”.

9 (b) DEVELOPMENT OF ESRD BUNDLED PAYMENT
10 SYSTEM.—

11 (1) IN GENERAL.—Section 1881(b) of the So-
12 cial Security Act (42 U.S.C. 1395rr(b)) is amended
13 by adding at the end the following new paragraph:
14 “(14)(A)(i) Subject to subparagraph (E), for services
15 furnished on or after January 1, 2011, the Secretary shall
16 implement a payment system under which a single pay-
17 ment is made under this title to a provider of services or
18 a renal dialysis facility for renal dialysis services (as de-
19 fined in subparagraph (B)) in lieu of any other payment
20 (including a payment adjustment under paragraph
21 (12)(B)(ii)) and for such services and items furnished pur-
22 suant to paragraph (4).

23 “(ii) In implementing the system under this para-
24 graph the Secretary shall ensure that the estimated total
25 amount of payments under this title for 2011 for renal

1 dialysis services shall equal 98 percent of the estimated
2 total amount of payments for renal dialysis services, in-
3 cluding payments under paragraph (12)(B)(ii), that would
4 have been made under this title with respect to services
5 furnished in 2011 if such system had not been imple-
6 mented. In making the estimation under subclause (I), the
7 Secretary shall use per patient utilization data from 2007,
8 2008, or 2009, whichever has the lowest per patient utili-
9 zation.

10 “(B) For purposes of this paragraph, the term ‘renal
11 dialysis services’ includes—

12 “(i) items and services included in the com-
13 posite rate for renal dialysis services as of December
14 31, 2010;

15 “(ii) erythropoiesis stimulating agents and any
16 oral form of such agents that are furnished to indi-
17 viduals for the treatment of end stage renal disease;

18 “(iii) other drugs and biologicals that are fur-
19 nished to individuals for the treatment of end stage
20 renal disease and for which payment was (before the
21 application of this paragraph) made separately
22 under this title, and any oral equivalent form of
23 such drug or biological; and

24 “(iv) diagnostic laboratory tests and other items
25 and services not described in clause (i) that are fur-

1 nished to individuals for the treatment of end stage
2 renal disease.

3 Such term does not include vaccines.

4 “(C) The system under this paragraph may provide
5 for payment on the basis of services furnished during a
6 week or month or such other appropriate unit of payment
7 as the Secretary specifies.

8 “(D) Such system—

9 “(i) shall include a payment adjustment based
10 on case mix that may take into account patient
11 weight, body mass index, comorbidities, length of
12 time on dialysis, age, race, ethnicity, and other ap-
13 propriate factors;

14 “(ii) shall include a payment adjustment for
15 high cost outliers due to unusual variations in the
16 type or amount of medically necessary care, includ-
17 ing variations in the amount of erythropoiesis stimu-
18 lating agents necessary for anemia management;

19 “(iii) shall include a payment adjustment that
20 reflects the extent to which costs incurred by low-
21 volume facilities (as defined by the Secretary) in fur-
22 nishing renal dialysis services exceed the costs in-
23 curred by other facilities in furnishing such services,
24 and for payment for renal dialysis services furnished
25 on or after January 1, 2011, and before January 1,

1 2014, such payment adjustment shall not be less
2 than 10 percent; and

3 “(iv) may include such other payment adjust-
4 ments as the Secretary determines appropriate, such
5 as a payment adjustment—

6 “(I) for pediatric providers of services and
7 renal dialysis facilities;

8 “(II) by a geographic index, such as the
9 index referred to in paragraph (12)(D), as the
10 Secretary determines to be appropriate; and

11 “(III) for providers of services or renal di-
12 alysis facilities located in rural areas.

13 The Secretary shall take into consideration the unique
14 treatment needs of children and young adults in estab-
15 lishing such system.

16 “(E)(i) The Secretary shall provide for a four-year
17 phase-in (in equal increments) of the payment amount
18 under the payment system under this paragraph, with
19 such payment amount being fully implemented for renal
20 dialysis services furnished on or after January 1, 2014.

21 “(ii) A provider of services or renal dialysis facility
22 may make a one-time election to be excluded from the
23 phase-in under clause (i) and be paid entirely based on
24 the payment amount under the payment system under this
25 paragraph. Such an election shall be made prior to Janu-

1 ary 1, 2011, in a form and manner specified by the Sec-
2 retary, and is final and may not be rescinded.

3 “(iii) The Secretary shall make an adjustment to the
4 payments under this paragraph for years during which the
5 phase-in under clause (i) is applicable so that the esti-
6 mated total amount of payments under this paragraph,
7 including payments under this subparagraph, shall equal
8 the estimated total amount of payments that would other-
9 wise occur under this paragraph without such phase-in.

10 “(F)(i) Subject to clause (ii), beginning in 2012, the
11 Secretary shall annually increase payment amounts estab-
12 lished under this paragraph by an ESRD market basket
13 percentage increase factor for a bundled payment system
14 for renal dialysis services that reflects changes over time
15 in the prices of an appropriate mix of goods and services
16 included in renal dialysis services minus 1.0 percentage
17 point.

18 “(ii) For years during which a phase-in of the pay-
19 ment system pursuant to subparagraph (E) is applicable,
20 the following rules shall apply to the portion of the pay-
21 ment under the system that is based on the payment of
22 the composite rate that would otherwise apply if the sys-
23 tem under this paragraph had not been enacted:

24 “(I) The update under clause (i) shall not
25 apply.

“(II) The Secretary shall annually increase such composite rate by the ESRD market basket percentage increase factor described in clause (i) minus 1.0 percentage point.

“(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the determination of payment amounts under subparagraph (A), the establishment of an appropriate unit of payment under subparagraph (C), the identification of renal dialysis services included in the bundled payment, the adjustments under subparagraph (D), the application of the phase-in under subparagraph (E), and the establishment of the market basket percentage increase factors under subparagraph (F).

“(H) Erythropoiesis stimulating agents and other drugs and biologicals shall be treated as prescribed and dispensed or administered and available only under part B if they are—

“(i) furnished to an individual for the treatment of end stage renal disease; and

“(ii) included in subparagraph (B) for purposes of payment under this paragraph.”.

(2) PROHIBITION OF UNBUNDLING.—Section 1862(a) of the Social Security Act (42 U.S.C.

1 1395y(a)), as amended by section 135(a)(2), is
2 amended—

3 (A) in paragraph (22), by striking “or” at
4 the end;

5 (B) in paragraph (23), by striking the pe-
6 riod at the end and inserting “; or”; and

7 (C) by inserting after paragraph (23) the
8 following new paragraph:

9 “(24) where such expenses are for renal dialysis
10 services (as defined in subparagraph (B) of section
11 1881(b)(14)) for which payment is made under such
12 section unless such payment is made under such sec-
13 tion to a provider of services or a renal dialysis facil-
14 ity for such services.”.

15 (3) CONFORMING AMENDMENTS.—(A) Section
16 1881(b) of the Social Security Act (42 U.S.C.
17 1395rr(b)) is amended—

18 (i) in paragraph (12)(A), by striking “In
19 lieu of payment” and inserting “Subject to
20 paragraph (14), in lieu of payment”;

21 (ii) in the second sentence of paragraph
22 (12)(F)—

23 (I) by inserting “or paragraph (14)”
24 after “this paragraph”; and

(II) by inserting “or under the system under paragraph (14)” after “subparagraph (B)”; and

(iii) in paragraph (13)—

(I) in subparagraph (A), in the matter preceding clause (i), by striking “The payment amounts” and inserting “Subject to paragraph (14), the payment amounts”; and

(II) in subparagraph (B)—

(aa) in clause (i), by striking “(i)” after “(B)” and by inserting “, subject to paragraph (14)” before the period at the end; and

(bb) by striking clause (ii).

(B) Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) is amended by inserting “, and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1881(b)(14)(B))” before the semicolon at the end.

(C) Section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395rr note) is repealed.

1 (4) RULE OF CONSTRUCTION.—Nothing in this
2 subsection or the amendments made by this sub-
3 section shall be construed as authorizing or requir-
4 ing the Secretary of Health and Human Services to
5 make payments under the payment system imple-
6 mented under paragraph (14)(A)(i) of section
7 1881(b) of the Social Security Act (42 U.S.C.
8 1395rr(b)), as added by paragraph (1), for any un-
9 recovered amount for any bad debt attributable to
10 deductible and coinsurance on items and services not
11 included in the basic case-mix adjusted composite
12 rate under paragraph (12) of such section as in ef-
13 fect before the date of the enactment of this Act.

14 (c) QUALITY INCENTIVES IN THE END-STAGE RENAL
15 DISEASE PROGRAM.—Section 1881 of the Social Security
16 Act (42 U.S.C. 1395rr) is amended by adding at the end
17 the following new subsection:

18 “(h) QUALITY INCENTIVES IN THE END-STAGE
19 RENAL DISEASE PROGRAM.—

20 “(1) QUALITY INCENTIVES.—

21 “(A) IN GENERAL.—With respect to renal
22 dialysis services (as defined in subsection
23 (b)(14)(B)) furnished on or after January 1,
24 2012, in the case of a provider of services or a
25 renal dialysis facility that does not meet the re-

1 requirement described in subparagraph (B) with
2 respect to the year, payments otherwise made
3 to such provider or facility under the system
4 under subsection (b)(14) for such services shall
5 be reduced by up to 2.0 percent, as determined
6 appropriate by the Secretary.

7 “(B) REQUIREMENT.—The requirement
8 described in this subparagraph is that the pro-
9 vider or facility meets (or exceeds) the total
10 performance score under paragraph (3) with re-
11 spect to performance standards established by
12 the Secretary with respect to measures specified
13 in paragraph (2).

14 “(C) NO EFFECT IN SUBSEQUENT
15 YEARS.—The reduction under subparagraph
16 (A) shall apply only with respect to the year in-
17 volved, and the Secretary shall not take into ac-
18 count such reduction in computing the single
19 payment amount under the system under para-
20 graph (14) in a subsequent year.

21 “(2) MEASURES.—

22 “(A) IN GENERAL.—The measures speci-
23 fied under this paragraph with respect to the
24 year involved shall include—

1 “(i) measures on anemia management
2 that reflect the labeling approved by the
3 Food and Drug Administration for such
4 management and measures on dialysis ade-
5 quacy;

6 “(ii) to the extent feasible, such meas-
7 ure (or measures) of patient satisfaction as
8 the Secretary shall specify; and

9 “(iii) such other measures as the Sec-
10 retary specifies, including, to the extent
11 feasible, measures on—

12 “(I) iron management;

13 “(II) bone mineral metabolism;

14 and

15 “(III) vascular access, including
16 for maximizing the placement of arte-
17 rial venous fistula.

18 “(B) USE OF ENDORSED MEASURES.—

19 “(i) IN GENERAL.—Subject to clause
20 (ii), any measure specified by the Secretary
21 under subparagraph (A)(iii) must have
22 been endorsed by the entity with a contract
23 under section 1890(a).

24 “(ii) EXCEPTION.—In the case of a
25 specified area or medical topic determined

appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(C) UPDATING MEASURES.—The Secretary shall establish a process for updating the measures specified under subparagraph (A) in consultation with interested parties.

“(D) CONSIDERATION.—In specifying measures under subparagraph (A), the Secretary shall consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure.

“(3) PERFORMANCE SCORES.—

“(A) TOTAL PERFORMANCE SCORE.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary shall develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance stand-

1 ards with respect to the measures selected
2 under paragraph (2) for a performance pe-
3 riod established under paragraph (4)(D)
4 (in this subsection referred to as the ‘total
5 performance score’).

6 “(ii) APPLICATION.—For providers of
7 services and renal dialysis facilities that do
8 not meet (or exceed) the total performance
9 score established by the Secretary, the Sec-
10 retary shall ensure that the application of
11 the methodology developed under clause (i)
12 results in an appropriate distribution of re-
13 ductions in payment under paragraph (1)
14 among providers and facilities achieving
15 different levels of total performance scores,
16 with providers and facilities achieving the
17 lowest total performance scores receiving
18 the largest reduction in payment under
19 paragraph (1)(A).

20 “(iii) WEIGHTING OF MEASURES.—In
21 calculating the total performance score, the
22 Secretary shall weight the scores with re-
23 spect to individual measures calculated
24 under subparagraph (B) to reflect prior-
25 ities for quality improvement, such as

weighting scores to ensure that providers of services and renal dialysis facilities have strong incentives to meet or exceed anemia management and dialysis adequacy performance standards, as determined appropriate by the Secretary.

“(B) PERFORMANCE SCORE WITH RESPECT TO INDIVIDUAL MEASURES.—The Secretary shall also calculate separate performance scores for each measure, including for dialysis adequacy and anemia management.

“(4) PERFORMANCE STANDARDS.—

“(A) ESTABLISHMENT.—Subject to subparagraph (E), the Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period with respect to a year (as established under subparagraph (D)).

“(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement, as determined appropriate by the Secretary.

“(C) TIMING.—The Secretary shall establish the performance standards under subpara-

1 graph (A) prior to the beginning of the per-
 2 formance period for the year involved.

3 “(D) PERFORMANCE PERIOD.—The Sec-
 4 retary shall establish the performance period
 5 with respect to a year. Such performance period
 6 shall occur prior to the beginning of such year.

7 “(E) SPECIAL RULE.—The Secretary shall
 8 initially use as the performance standard for
 9 the measures specified under paragraph
 10 (2)(A)(i) for a provider of services or a renal di-
 11 alysis facility the lesser of—

12 “(i) the performance of such provider
 13 or facility for such measures in the year
 14 selected by the Secretary under the second
 15 sentence of subsection (b)(14)(A)(ii); or

16 “(ii) a performance standard based on
 17 the national performance rates for such
 18 measures in a period determined by the
 19 Secretary.

20 “(5) LIMITATION ON REVIEW.—There shall be
 21 no administrative or judicial review under section
 22 1869, section 1878, or otherwise of the following:

23 “(A) The determination of the amount of
 24 the payment reduction under paragraph (1).

1 “(B) The establishment of the performance
2 standards and the performance period under
3 paragraph (4).

4 “(C) The specification of measures under
5 paragraph (2).

6 “(D) The methodology developed under
7 paragraph (3) that is used to calculate total
8 performance scores and performance scores for
9 individual measures.

10 “(6) PUBLIC REPORTING.—

11 “(A) IN GENERAL.—The Secretary shall
12 establish procedures for making information re-
13 garding performance under this subsection
14 available to the public, including—

15 “(i) the total performance score
16 achieved by the provider of services or
17 renal dialysis facility under paragraph (3)
18 and appropriate comparisons of providers
19 of services and renal dialysis facilities to
20 the national average with respect to such
21 scores; and

22 “(ii) the performance score achieved
23 by the provider or facility with respect to
24 individual measures.

1 “(B) OPPORTUNITY TO REVIEW.—The pro-
2 cedures established under subparagraph (A)
3 shall ensure that a provider of services and a
4 renal dialysis facility has the opportunity to re-
5 view the information that is to be made public
6 with respect to the provider or facility prior to
7 such data being made public.

8 “(C) CERTIFICATES.—

9 “(i) IN GENERAL.—The Secretary
10 shall provide certificates to providers of
11 services and renal dialysis facilities who
12 furnish renal dialysis services under this
13 section to display in patient areas. The
14 certificate shall indicate the total perform-
15 ance score achieved by the provider or fa-
16 cility under paragraph (3).

17 “(ii) DISPLAY.—Each facility or pro-
18 vider receiving a certificate under clause (i)
19 shall prominently display the certificate at
20 the provider or facility.

21 “(D) WEB-BASED LIST.—The Secretary
22 shall establish a list of providers of services and
23 renal dialysis facilities who furnish renal dialy-
24 sis services under this section that indicates the
25 total performance score and the performance

1 score for individual measures achieved by the
2 provider and facility under paragraph (3). Such
3 information shall be posted on the Internet
4 website of the Centers for Medicare & Medicaid
5 Services in an easily understandable format.”.

6 (d) GAO REPORT ON ESRD BUNDLING SYSTEM AND
7 QUALITY INITIATIVE.—Not later than March 1, 2013, the
8 Comptroller General of the United States shall submit to
9 Congress a report on the implementation of the payment
10 system under subsection (b)(14) of section 1881 of the
11 Social Security Act (as added by subsection (b)) for renal
12 dialysis services and related services (defined in subpara-
13 graph (B) of such subsection (b)(14)) and the quality ini-
14 tiative under subsection (h) of such section 1881 (as
15 added by subsection (b)). Such report shall include the fol-
16 lowing information:

17 (1) The changes in utilization rates for
18 erythropoiesis stimulating agents.

19 (2) The mode of administering such agents, in-
20 cluding information on the proportion of individuals
21 receiving such agents intravenously as compared to
22 subcutaneously.

23 (3) An analysis of the payment adjustment
24 under subparagraph (D)(iii) of such subsection
25 (b)(14), including an examination of the extent to

1 which costs incurred by rural, low-volume providers
2 and facilities (as defined by the Secretary) in fur-
3 nishing renal dialysis services exceed the costs in-
4 curred by other providers and facilities in furnishing
5 such services, and a recommendation regarding the
6 appropriateness of such adjustment.

7 (4) The changes, if any, in utilization rates of
8 drugs and biologicals that the Secretary identifies
9 under subparagraph (B)(iii) of such subsection
10 (b)(14), and any oral equivalent or oral substitutable
11 forms of such drugs and biologicals or of drugs and
12 biologicals described in clause (ii), that have oc-
13 curred after implementation of the payment system
14 under such subsection (b)(14).

15 (5) Any other information or recommendations
16 for legislative and administrative actions determined
17 appropriate by the Comptroller General.

18 **Subtitle D—Provisions Relating to**
19 **Part C**

20 **SEC. 161. PHASE-OUT OF INDIRECT MEDICAL EDUCATION**
21 **(IME).**

22 (a) IN GENERAL.—Section 1853(k) of the Social Se-
23 curity Act (42 U.S.C. 1395w-23(k)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”; and

(2) by adding at the end the following new paragraph:

“(4) PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM CAPITATION RATES.—

“(A) IN GENERAL.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary’s estimate of the standardized costs for payments under section 1886(d)(5)(B) in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

“(B) PERCENTAGES DEFINED.—For purposes of this paragraph:

“(i) PHASE-IN PERCENTAGE.—The term ‘phase-in percentage’ means, for an area for a year, the ratio (expressed as a

1 percentage, but in no case greater than
2 100 percent) of—

3 “(I) the maximum cumulative ad-
4 justment percentage for the year (as
5 defined in clause (ii)); to

6 “(II) the standardized IME cost
7 percentage (as defined in clause (iii))
8 for the area and year.

9 “(ii) MAXIMUM CUMULATIVE ADJUST-
10 MENT PERCENTAGE.—The term ‘maximum
11 cumulative adjustment percentage’ means,
12 for—

13 “(I) 2010, 0.60 percent; and

14 “(II) a subsequent year, the max-
15 imum cumulative adjustment percent-
16 age for the previous year increased by
17 0.60 percentage points.

18 “(iii) STANDARDIZED IME COST PER-
19 CENTAGE.—The term ‘standardized IME
20 cost percentage’ means, for an area for a
21 year, the per capita costs for payments
22 under section 1886(d)(5)(B) (expressed as
23 a percentage of the fee-for-service amount
24 specified in subparagraph (C)) for the area
25 and the year.

1 “(C) FEE-FOR-SERVICE AMOUNT.—The
2 fee-for-service amount specified in this subpara-
3 graph for an area for a year is the amount
4 specified under subsection (c)(1)(D) for the
5 area and the year.”.

6 (b) EXCLUDING ADJUSTMENT FROM THE UP-
7 DATE.—Section 1853(k)(1)(B)(i) of the Social Security
8 Act (42 U.S.C. 1395w-23(k)(1)(B)(i)) is amended by
9 striking “paragraph (2)” and inserting “paragraphs (2)
10 and (4)”.

11 (c) HOLD HARMLESS FOR PACE PROGRAM PAY-
12 MENTS.—Section 1894(d) of the Social Security Act (42
13 U.S.C. 1395eee(d)) is amended by adding at the end the
14 following new paragraph:

15 “(3) CAPITATION RATES DETERMINED WITH-
16 OUT REGARD TO THE PHASE-OUT OF THE INDIRECT
17 COSTS OF MEDICAL EDUCATION FROM THE ANNUAL
18 MEDICARE ADVANTAGE CAPITATION RATE.—Capita-
19 tion amounts under this subsection shall be deter-
20 mined without regard to the application of section
21 1853(k)(4).”.

1 **SEC. 162. REVISIONS TO REQUIREMENTS FOR MEDICARE**
2 **ADVANTAGE PRIVATE FEE-FOR-SERVICE**
3 **PLANS.**

4 (a) REQUIREMENTS TO ASSURE ACCESS TO NET-
5 WORK COVERAGE.—

6 (1) INDIVIDUAL MARKET.—Section 1852(d) of
7 the Social Security Act (42 U.S.C. 1395w–22(d)) is
8 amended—

9 (A) in paragraph (4), in the second sen-
10 tence, by striking “The Secretary” and insert-
11 ing “Subject to paragraph (5), the Secretary”;
12 and

13 (B) by adding at the end the following new
14 paragraph:

15 “(5) REQUIREMENT OF CERTAIN NON-
16 EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-
17 FOR-SERVICE PLANS TO USE CONTRACTS WITH PRO-
18 VIDERS.—

19 “(A) IN GENERAL.—For plan year 2011
20 and subsequent plan years, in the case of a
21 Medicare Advantage private fee-for-service plan
22 not described in paragraph (1) or (2) of section
23 1857(i) operating in a network area (as defined
24 in subparagraph (B)), the plan shall meet the
25 access standards under paragraph (4) in that
26 area only through entering into written con-

1 tracts as provided for under subparagraph (B)
2 of such paragraph and not, in whole or in part,
3 through the establishment of payment rates
4 meeting the requirements under subparagraph
5 (A) of such paragraph.

6 “(B) NETWORK AREA DEFINED.—For pur-
7 poses of subparagraph (A), the term ‘network
8 area’ means, for a plan year, an area which the
9 Secretary identifies (in the Secretary’s an-
10 nouncement of the proposed payment rates for
11 the previous plan year under section
12 1853(b)(1)(B)) as having at least 2 network-
13 based plans (as defined in subparagraph (C))
14 with enrollment under this part as of the first
15 day of the year in which such announcement is
16 made.

17 “(C) NETWORK-BASED PLAN DEFINED.—

18 “(i) IN GENERAL.—For purposes of
19 subparagraph (B), the term ‘network-
20 based plan’ means—

21 “(I) except as provided in clause
22 (ii), a Medicare Advantage plan that
23 is a coordinated care plan described in
24 section 1851(a)(2)(A)(i);

1 “(II) a network-based MSA plan;

2 and

3 “(III) a reasonable cost reim-
4 bursement plan under section 1876.

5 “(ii) EXCLUSION OF NON-NETWORK
6 REGIONAL PPOS.—The term ‘network-
7 based plan’ shall not include an MA re-
8 gional plan that, with respect to the area,
9 meets access adequacy standards under
10 this part substantially through the author-
11 ity of section 422.112(a)(1)(ii) of title 42,
12 Code of Federal Regulations, rather than
13 through written contracts.”.

14 (2) EMPLOYER PLANS.—Section 1852(d) of the
15 Social Security Act (42 U.S.C. 1395w–22(d)), as
16 amended by paragraph (1), is amended—

17 (A) in paragraph (4), in the second sen-
18 tence, by striking “paragraph (5)” and insert-
19 ing “paragraphs (5) and (6)”; and

20 (B) by adding at the end the following new
21 paragraph:

22 “(6) REQUIREMENT OF ALL EMPLOYER MEDI-
23 CARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS
24 TO USE CONTRACTS WITH PROVIDERS.—For plan
25 year 2011 and subsequent plan years, in the case of

1 a Medicare Advantage private fee-for-service plan
2 that is described in paragraph (1) or (2) of section
3 1857(i), the plan shall meet the access standards
4 under paragraph (4) only through entering into writ-
5 ten contracts as provided for under subparagraph
6 (B) of such paragraph and not, in whole or in part,
7 through the establishment of payment rates meeting
8 the requirements under subparagraph (A) of such
9 paragraph.”.

10 (3) ACCESS REQUIREMENTS.—

11 (A) IN GENERAL.—Section 1852(d)(4)(B)
12 of the Social Security Act (42 U.S.C. 1395w-
13 22(d)(4)(B)) is amended by striking “a suffi-
14 cient number” through “terms of the plan” and
15 inserting “a sufficient number and range of
16 providers within such category to meet the ac-
17 cess standards in subparagraphs (A) through
18 (E) of paragraph (1)”.

19 (B) EFFECTIVE DATE.—The amendment
20 made by subparagraph (A) shall apply to plan
21 year 2010 and subsequent plan years.

22 (b) CLARIFICATION REGARDING UTILIZATION.—Sec-
23 tion 1859(b)(2) of the Social Security Act (42 U.S.C.
24 1395w-28(b)(2)) is amended by adding at the end the fol-
25 lowing flush sentence:

1 “Nothing in subparagraph (B) shall be construed to
 2 preclude a plan from varying rates for such a pro-
 3 vider based on the specialty of the provider, the loca-
 4 tion of the provider, or other factors related to such
 5 provider that are not related to utilization, or to pre-
 6 clude a plan from increasing rates for such a pro-
 7 vider based on increased utilization of specified pre-
 8 ventive or screening services.”.

9 **SEC. 163. REVISIONS TO QUALITY IMPROVEMENT PRO-**
 10 **GRAMS.**

11 (a) REQUIREMENT FOR MA PRIVATE FEE-FOR-
 12 SERVICE AND MSA PLANS TO HAVE A QUALITY IM-
 13 PROVEMENT PROGRAM.—

14 (1) IN GENERAL.—Section 1852(e)(1) of the
 15 Social Security Act (42 U.S.C. 1395w–112(e)(1)) is
 16 amended by striking “(other than an MA private
 17 fee-for-service plan or an MSA plan)”.

18 (2) EFFECTIVE DATE.—The amendment made
 19 by paragraph (1) shall apply to plan years beginning
 20 on or after January 1, 2010.

21 (b) DATA COLLECTION REQUIREMENTS FOR MA RE-
 22 GIONAL PLANS, MA PRIVATE FEE-FOR-SERVICE PLANS,
 23 AND MSA PLANS.—

1 (1) IN GENERAL.—Section 1852(e)(3)(A) of the
2 Social Security Act (42 U.S.C. 1395w-22(e)(3)(A))
3 is amended—

4 (A) in clause (i), by adding at the end the
5 following new sentence: “With respect to MA
6 private fee-for-service plans and MSA plans,
7 such requirements may not exceed the require-
8 ments under this subparagraph with respect to
9 MA local plans that are preferred provider or-
10 ganization plans, except that the limitation
11 under clause (iii) shall not apply and such re-
12 quirements shall apply regardless of whether or
13 not the services are furnished by providers of
14 services, physicians, or other health care practi-
15 tioners and suppliers that have contracts with
16 the organization offering the MA private fee-
17 for-service plan or the MSA plan.”

18 (B) by striking clause (ii)—

19 (C) in clause (iii)—

20 (i) in the heading—

21 (I) by inserting “LOCAL” after
22 “TO”; and

23 (II) by inserting “AND MA RE-
24 GIONAL PLANS” after “ORGANIZA-
25 TIONS”; and

1 (ii) by inserting “and to MA regional
2 plans” after “organization plans”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by paragraph (1) shall apply to plan years beginning
5 on or after January 1, 2010.

6 **SEC. 164. REVISIONS RELATING TO SPECIALIZED MEDI-**
7 **CARE ADVANTAGE PLANS FOR SPECIAL**
8 **NEEDS INDIVIDUALS.**

9 (a) EXTENSION OF AUTHORITY TO RESTRICT EN-
10 ROLLMENT.—Section 1859(f) of the Social Security Act
11 (42 U.S.C. 1395w–28(f)), as amended by section 108(a)
12 of the Medicare, Medicaid, and SCHIP Extension Act of
13 2007 (Public Law 110–173) is amended by striking
14 “2010” and inserting “2011”.

15 (b) MORATORIUM ON AUTHORITY TO DESIGNATE
16 OTHER PLANS AS SPECIALIZED MA PLANS.—During the
17 period beginning on January 1, 2010, and ending on De-
18 cember 31, 2010, the Secretary of Health and Human
19 Services may not exercise the authority provided under
20 section 231(d) of the Medicare Prescription Drug, Im-
21 provement, and Modernization Act of 2003 (42 U.S.C.
22 1395w–21 note) to designate other plans as specialized
23 MA plans for special needs individuals.

24 (c) REQUIREMENTS FOR ENROLLMENT.—

1 (1) IN GENERAL.—Section 1859 of the Social
2 Security Act (42 U.S.C. 1395w–28) is amended—

3 (A) in subsection (b)(6)(A), by inserting
4 “and that, as of January 1, 2010, meets the
5 applicable requirements of paragraph (2), (3),
6 or (4) of subsection (f), as the case may be” be-
7 fore the period at the end; and

8 (B) in subsection (f)—

9 (i) by amending the heading to read
10 as follows: “REQUIREMENTS REGARDING
11 ENROLLMENT IN SPECIALIZED MA PLANS
12 FOR SPECIAL NEEDS INDIVIDUALS”;

13 (ii) by designating the sentence begin-
14 ning “In the case of” as paragraph (1)
15 with the heading “REQUIREMENTS FOR
16 ENROLLMENT.—” and with appropriate in-
17 dentation; and

18 (iii) by adding at the end the fol-
19 lowing new paragraphs:

20 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-
21 TUTIONAL SNPS.—In the case of a specialized MA
22 plan for special needs individuals described in sub-
23 section (b)(6)(B)(i), the applicable requirements de-
24 scribed in this paragraph are as follows:

1 “(A) Each individual that enrolls in the
2 plan on or after January 1, 2010, is a special
3 needs individuals described in subsection
4 (b)(6)(B)(i). In the case of an individual who is
5 living in the community but requires an institu-
6 tional level of care, such individual shall not be
7 considered a special needs individual described
8 in subsection (b)(6)(B)(i) unless the determina-
9 tion that the individual requires an institutional
10 level of care was made—

11 “(i) using a State assessment tool of
12 the State in which the individual resides;
13 and

14 “(ii) by an entity other than the orga-
15 nization offering the plan.

16 “(B) The plan meets the requirements de-
17 scribed in paragraph (5).

18 “(3) ADDITIONAL REQUIREMENTS FOR DUAL
19 SNPS.—In the case of a specialized MA plan for spe-
20 cial needs individuals described in subsection
21 (b)(6)(B)(ii), the applicable requirements described
22 in this paragraph are as follows:

23 “(A) Each individual that enrolls in the
24 plan on or after January 1, 2010, is a special

1 needs individuals described in subsection
2 (b)(6)(B)(ii).

3 “(B) The plan meets the requirements de-
4 scribed in paragraph (5).

5 “(C) The plan provides each prospective
6 enrollee, prior to enrollment, with a comprehen-
7 sive written statement (using standardized con-
8 tent and format established by the Secretary)
9 that describes—

10 “(i) the benefits and cost-sharing pro-
11 tections that the individual is entitled to
12 under the State Medicaid program under
13 title XIX; and

14 “(ii) which of such benefits and cost-
15 sharing protections are covered under the
16 plan.

17 Such statement shall be included with any de-
18 scription of benefits offered by the plan.

19 “(D) The plan has a contract with the
20 State Medicaid agency to provide benefits, or
21 arrange for benefits to be provided, for which
22 such individual is entitled to receive as medical
23 assistance under title XIX. Such benefits may
24 include long-term care services consistent with
25 State policy.

1 “(4) ADDITIONAL REQUIREMENTS FOR SEVERE
2 OR DISABLING CHRONIC CONDITION SNPS.—In the
3 case of a specialized MA plan for special needs indi-
4 viduals described in subsection (b)(6)(B)(iii), the ap-
5 plicable requirements described in this paragraph
6 are as follows:

7 “(A) Each individual that enrolls in the
8 plan on or after January 1, 2010, is a special
9 needs individual described in subsection
10 (b)(6)(B)(iii).

11 “(B) The plan meets the requirements de-
12 scribed in paragraph (5).”.

13 (2) AUTHORITY TO OPERATE BUT NO SERVICE
14 AREA EXPANSION FOR DUAL SNPS THAT DO NOT
15 MEET CERTAIN REQUIREMENTS.—Notwithstanding
16 subsection (f) of section 1859 of the Social Security
17 Act (42 U.S.C. 1395w–28), during the period begin-
18 ning on January 1, 2010, and ending on December
19 31, 2010, in the case of a specialized Medicare Ad-
20 vantage plan for special needs individuals described
21 in subsection (b)(6)(B)(ii) of such section, as
22 amended by this section, that does not meet the re-
23 quirement described in subsection (f)(3)(D) of such
24 section, the Secretary of Health and Human Serv-
25 ices—

(A) shall permit such plan to be offered under part C of title XVIII of such Act; and

(B) shall not permit an expansion of the service area of the plan under such part C.

(3) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

(4) NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section.

(d) CARE MANAGEMENT REQUIREMENTS FOR ALL SNPs.—

1 (1) REQUIREMENTS.—Section 1859(f) of the
2 Social Security Act (42 U.S.C. 1395w-28(f)), as
3 amended by subsection (c)(1), is amended by adding
4 at the end the following new paragraph:

5 “(5) CARE MANAGEMENT REQUIREMENTS FOR
6 ALL SNPS.—The requirements described in this
7 paragraph are that the organization offering a spe-
8 cialized MA plan for special needs individuals de-
9 scribed in subsection (b)(6)(B)(i)—

10 “(A) have in place an evidenced-based
11 model of care with appropriate networks of pro-
12 viders and specialists; and

13 “(B) with respect to each individual en-
14 rolled in the plan—

15 “(i) conduct an initial assessment and
16 an annual reassessment of the individual’s
17 physical, psychosocial, and functional
18 needs;

19 “(ii) develop a plan, in consultation
20 with the individual as feasible, that identi-
21 fies goals and objectives, including measur-
22 able outcomes as well as specific services
23 and benefits to be provided; and

24 “(iii) use an interdisciplinary team in
25 the management of care.”.

(2) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

“(6) REVIEW TO ENSURE COMPLIANCE WITH CARE MANAGEMENT REQUIREMENTS FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In conjunction with the periodic audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (1), the Secretary shall conduct a review to ensure that such organization offering the plan meets the requirements described in section 1859(f)(5).”.

(e) CLARIFICATION OF THE DEFINITION OF A SEVERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED NEEDS INDIVIDUAL.—

(1) IN GENERAL.—Section 1859(b)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)) is amended by inserting “who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and re-

1 quire specialized delivery systems across domains of
2 care” before the period at the end.

3 (2) PANEL.—The Secretary of Health and
4 Human Services shall convene a panel of clinical ad-
5 visors to determine the conditions that meet the def-
6 inition of severe and disabling chronic conditions
7 under section 1859(b)(6)(B)(iii) of the Social Secu-
8 rity Act (42 U.S.C. 1395w–28(b)(6)(B)(iii)), as
9 amended by paragraph (1). The panel shall include
10 the Director of the Agency for Healthcare Research
11 and Quality (or the Director’s designee).

12 (f) SPECIAL REQUIREMENTS REGARDING QUALITY
13 REPORTING FOR SPECIALIZED MA PLANS FOR SPECIAL
14 NEEDS INDIVIDUALS.—

15 (1) IN GENERAL.—Section 1852(e)(3)(A) of the
16 Social Security Act (42 U.S.C. 1395w–22(e)(3)(A)),
17 as amended by section 163, is amended by inserting
18 after clause (i) the following new clause:

19 “(ii) SPECIAL REQUIREMENTS FOR
20 SPECIALIZED MA PLANS FOR SPECIAL
21 NEEDS INDIVIDUALS.—In addition to the
22 data required to be collected, analyzed, and
23 reported under clause (i) and notwith-
24 standing the limitations under subpara-
25 graph (B), as part of the quality improve-

1 ment program under paragraph (1), each
2 MA organization offering a specialized
3 Medicare Advantage plan for special needs
4 individuals shall provide for the collection,
5 analysis, and reporting of data that per-
6 mits the measurement of health outcomes
7 and other indices of quality with respect to
8 the requirements described in paragraphs
9 (2) through (5) of subsection (f). Such
10 data may be based on claims data and
11 shall be at the plan level.”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall take effect on a date specified
14 by the Secretary of Health and Human Services (but
15 in no case later than January 1, 2010), and shall
16 apply to all specialized Medicare Advantage plans
17 for special needs individuals regardless of when the
18 plan first entered the Medicare Advantage program
19 under part C of title XVIII of the Social Security
20 Act.

21 (g) EFFECTIVE DATE AND APPLICATION.—The
22 amendments made by subsections (c)(1), (d), and (e)(1)
23 shall apply to plan years beginning on or after January
24 1, 2010, and shall apply to all specialized Medicare Advan-
25 tage plans for special needs individuals regardless of when

1 the plan first entered the Medicare Advantage program
2 under part C of title XVIII of the Social Security Act.

3 (h) NO AFFECT ON MEDICAID BENEFITS FOR
4 DUALS.—Nothing in the provisions of, or amendments
5 made by, this section shall affect the benefits available
6 under the Medicaid program under title XIX of the Social
7 Security Act for special needs individuals described in sec-
8 tion 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w-
9 28(b)(6)(B)(ii)).

10 **SEC. 165. LIMITATION ON OUT-OF-POCKET COSTS FOR**
11 **DUAL ELIGIBLES AND QUALIFIED MEDICARE**
12 **BENEFICIARIES ENROLLED IN A SPECIAL-**
13 **IZED MEDICARE ADVANTAGE PLAN FOR SPE-**
14 **CIAL NEEDS INDIVIDUALS.**

15 (a) IN GENERAL.—Section 1852(a) of the Social Se-
16 curity Act (42 U.S.C. 1395w-22(a)) is amended by adding
17 at the end the following new paragraph:

18 “(7) LIMITATION ON COST-SHARING FOR DUAL
19 ELIGIBLES AND QUALIFIED MEDICARE BENE-
20 FICIARIES.—In the case of an individual who is a
21 full-benefit dual eligible individual (as defined in sec-
22 tion 1935(c)(6)) or a qualified medicare beneficiary
23 (as defined in section 1905(p)(1)) and who is en-
24 rolled in a specialized Medicare Advantage plan for
25 special needs individuals described in section

1 1859(b)(6)(B)(ii), the plan may not impose cost-
2 sharing that exceeds the amount of cost-sharing that
3 would be permitted with respect to the individual
4 under title XIX if the individual were not enrolled
5 in such plan.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall apply to plan years beginning on or
8 after January 1, 2010.

9 **SEC. 166. ADJUSTMENT TO THE MEDICARE ADVANTAGE**
10 **STABILIZATION FUND.**

11 Section 1858(e)(2)(A)(i) of the Social Security Act
12 (42 U.S.C. 1395w-27a(e)(2)(A)(i)), as amended by sec-
13 tion 110 of the Medicare, Medicaid, and SCHIP Extension
14 Act of 2007 (Public Law 110-173), is amended—

15 (1) by striking “2013” and inserting “2014”;

16 and

17 (2) by striking “\$1,790,000,000” and inserting

18 “\$1”.

19 **SEC. 167. ACCESS TO MEDICARE REASONABLE COST CON-**
20 **TRACT PLANS.**

21 (a) EXTENSION OF REASONABLE COST CON-
22 TRACTS.—Section 1876(h)(5)(C)(ii) of the Social Security
23 Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), as amended by sec-
24 tion 109 of the Medicare, Medicaid, and SCHIP Extension
25 Act of 2007 (Public Law 110-173), is amended by strik-

1 ing “January 1, 2009” and inserting “January 1, 2010”
 2 in the matter preceding subclause (I).

3 (b) REQUIREMENT FOR AT LEAST TWO MEDICARE
 4 ADVANTAGE ORGANIZATIONS TO BE OFFERING A PLAN
 5 IN AN AREA FOR THE PROHIBITION TO BE APPLICA-
 6 BLE.—Subclauses (I) and (II) of section 1876(h)(5)(C)(ii)
 7 of the Social Security Act (42 U.S.C.
 8 1395mm(h)(5)(C)(ii)) are each amended by inserting “,
 9 provided that all such plans are not offered by the same
 10 Medicare Advantage organization” after “clause (iii)”.

11 (c) REVISION OF REQUIREMENTS FOR A PLAN THAT
 12 ARE USED TO DETERMINE IF PROHIBITION IS APPLICA-
 13 BLE.—

14 (1) IN GENERAL.—Section 1876(h)(5)(C)(iii)(I)
 15 of the Social Security Act (42 U.S.C.
 16 1395mm(h)(5)(C)(iii)(I)) is amended by inserting
 17 “that are not in another Metropolitan Statistical
 18 Area with a population of more than 250,000” after
 19 “such Metropolitan Statistical Area”.

20 (2) CLARIFICATION.—Section
 21 1876(h)(5)(C)(iii)(I) of the Social Security Act (42
 22 U.S.C. 1395mm(h)(5)(C)(iii)(I)) is amended by add-
 23 ing at the end the following new sentence: “If the
 24 service area includes a portion in more than 1 Met-
 25 ropolitan Statistical Area with a population of more

1 than 250,000, the minimum enrollment determina-
2 tion under the preceding sentence shall be made
3 with respect to each such Metropolitan Statistical
4 Area (and such applicable contiguous counties to
5 such Metropolitan Statistical Area).”.

6 (d) GAO STUDY AND REPORT.—

7 (1) STUDY.—The Comptroller General of the
8 United States shall conduct a study of the reasons
9 (if any) why reasonable cost contracts under section
10 1876(h) of the Social Security Act (42 U.S.C.
11 1395mm(h)) are unable to become Medicare Advan-
12 tage plans under part C of title XVIII of such Act.

13 (2) REPORT.—Not later than December 31,
14 2009, the Comptroller General of the United States
15 shall submit to Congress a report containing the re-
16 sults of the study conducted under paragraph (1),
17 together with recommendations for such legislation
18 and administrative action as the Comptroller Gen-
19 eral determines appropriate.

20 **SEC. 168. MEDPAC STUDY AND REPORT ON QUALITY MEAS-**
21 **URES.**

22 (a) STUDY.—The Medicare Payment Advisory Com-
23 mission shall conduct a study on how comparable meas-
24 ures of performance and patient experience can be col-
25 lected and reported by 2011 for the Medicare Advantage

1 program under part C of title XVIII of the Social Security
2 Act and the original Medicare fee-for-service program
3 under parts A and B of such title. Such study shall ad-
4 dress technical issues, such as data requirements, in addi-
5 tion to issues relating to appropriate quality benchmarks
6 that—

7 (1) compare the quality of care Medicare bene-
8 ficiaries receive across Medicare Advantage plans;
9 and

10 (2) compare the quality of care Medicare bene-
11 ficiaries receive under Medicare Advantage plans
12 and under the original Medicare fee-for-service pro-
13 gram.

14 (b) REPORT.—Not later than March 31, 2010, the
15 Medicare Payment Advisory Commission shall submit to
16 Congress a report containing the results of the study con-
17 ducted under subsection (a), together with recommenda-
18 tions for such legislation and administrative action as the
19 Medicare Payment Advisory Commission determines ap-
20 propriate.

21 **SEC. 169. MEDPAC STUDY AND REPORT ON MEDICARE AD-**
22 **VANTAGE PAYMENTS.**

23 (a) STUDY.—The Medicare Payment Advisory Com-
24 mission (in this section referred to as the “Commission”)
25 shall conduct a study of the following:

(1) The correlation between—

(A) the costs that Medicare Advantage organizations with respect to Medicare Advantage plans incur in providing coverage under the plan for items and services covered under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, as reflected in plan bids; and

(B) county-level spending under such original Medicare fee-for-service program on a per capita basis, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services.

The study with respect to the issue described in the preceding sentence shall include differences in correlation statistics by plan type and geographic area.

(2) Based on these results of the study with respect to the issue described in paragraph (1), and other data the Commission determines appropriate—

(A) alternate approaches to payment with respect to a Medicare beneficiary enrolled in a Medicare Advantage plan other than through county-level payment area equivalents.

1 (B) the accuracy and completeness of
2 county-level estimates of per capita spending
3 under such original Medicare fee-for-service
4 program (including counties in Puerto Rico), as
5 used to determine the annual Medicare Advan-
6 tage capitation rate under section 1853 of the
7 Social Security Act (42 U.S.C. 1395w-23), and
8 whether such estimates include—

9 (i) expenditures with respect to Medi-
10 care beneficiaries at facilities of the De-
11 partment of Veterans Affairs; and

12 (ii) all appropriate administrative ex-
13 penses, including claims processing.

14 (3) Ways to improve the accuracy and com-
15 pleteness of county-level estimates of per capita
16 spending described in paragraph (2)(B).

17 (b) REPORT.—Not later than March 31, 2010, the
18 Commission shall submit to Congress a report containing
19 the results of the study conducted under subsection (a),
20 together with recommendations for such legislation and
21 administrative action as the Commission determines ap-
22 propriate.

Subtitle E—Provisions Relating to Part D

PART I—IMPROVING PHARMACY ACCESS

SEC. 171. PROMPT PAYMENT BY PRESCRIPTION DRUG PLANS AND MA-PD PLANS UNDER PART D.

(a) PROMPT PAYMENT BY PRESCRIPTION DRUG
PLANS.—Section 1860D–12(b) of the Social Security Act
(42 U.S.C. 1395w–112(b)) is amended by adding at the
end the following new paragraph:

“(4) PROMPT PAYMENT OF CLEAN CLAIMS.—

“(A) PROMPT PAYMENT.—

“(i) IN GENERAL.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility) under this part within the applicable number of calendar days after the date on which the claim is received.

1 “(ii) CLEAN CLAIM DEFINED.—In this
2 paragraph, the term ‘clean claim’ means a
3 claim that has no defect or impropriety
4 (including any lack of any required sub-
5 stantiating documentation) or particular
6 circumstance requiring special treatment
7 that prevents timely payment from being
8 made on the claim under this part.

9 “(iii) DATE OF RECEIPT OF CLAIM.—
10 In this paragraph, a claim is considered to
11 have been received—

12 “(I) with respect to claims sub-
13 mitted electronically, on the date on
14 which the claim is transferred; and

15 “(II) with respect to claims sub-
16 mitted otherwise, on the 5th day after
17 the postmark date of the claim or the
18 date specified in the time stamp of the
19 transmission.

20 “(B) APPLICABLE NUMBER OF CALENDAR
21 DAYS DEFINED.—In this paragraph, the term
22 ‘applicable number of calendar days’ means—

23 “(i) with respect to claims submitted
24 electronically, 14 days; and

“(ii) with respect to claims submitted otherwise, 30 days.

“(C) INTEREST PAYMENT.—

“(i) IN GENERAL.—Subject to clause (ii), if payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in subparagraph (B)) after a clean claim is received, the PDP sponsor shall pay interest to the pharmacy that submitted the claim at a rate equal to the weighted average of interest on 3-month marketable Treasury securities determined for such period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment is made (as determined under subparagraph (D)(iv)). Interest amounts paid under this subparagraph shall not be counted against the administrative costs of a prescription drug plan or treated as allowable risk corridor costs under section 1860D–15(e).

“(ii) AUTHORITY NOT TO CHARGE INTEREST.—The Secretary may provide that

1 a PDP sponsor is not charged interest
2 under clause (i) in the case where there
3 are exigent circumstances, including nat-
4 ural disasters and other unique and unex-
5 pected events, that prevent the timely proc-
6 essing of claims.

7 “(D) PROCEDURES INVOLVING CLAIMS.—

8 “(i) CLAIM DEEMED TO BE CLEAN.—

9 A claim is deemed to be a clean claim if
10 the PDP sponsor involved does not provide
11 notice to the claimant of any deficiency in
12 the claim—

13 “(I) with respect to claims sub-
14 mitted electronically, within 10 days
15 after the date on which the claim is
16 received; and

17 “(II) with respect to claims sub-
18 mitted otherwise, within 15 days after
19 the date on which the claim is re-
20 ceived.

21 “(ii) CLAIM DETERMINED TO NOT BE
22 A CLEAN CLAIM.—

23 “(I) IN GENERAL.—If a PDP
24 sponsor determines that a submitted
25 claim is not a clean claim, the PDP

1 sponsor shall, not later than the end
2 of the period described in clause (i),
3 notify the claimant of such determina-
4 tion. Such notification shall specify all
5 defects or improprieties in the claim
6 and shall list all additional informa-
7 tion or documents necessary for the
8 proper processing and payment of the
9 claim.

10 “(II) DETERMINATION AFTER
11 SUBMISSION OF ADDITIONAL INFOR-
12 MATION.—A claim is deemed to be a
13 clean claim under this paragraph if
14 the PDP sponsor involved does not
15 provide notice to the claimant of any
16 defect or impropriety in the claim
17 within 10 days of the date on which
18 additional information is received
19 under subclause (I).

20 “(iii) OBLIGATION TO PAY.—A claim
21 submitted to a PDP sponsor that is not
22 paid or contested by the sponsor within the
23 applicable number of days (as defined in
24 subparagraph (B)) after the date on which
25 the claim is received shall be deemed to be

1 a clean claim and shall be paid by the
2 PDP sponsor in accordance with subpara-
3 graph (A).

4 “(iv) DATE OF PAYMENT OF CLAIM.—
5 Payment of a clean claim under such sub-
6 paragraph is considered to have been made
7 on the date on which—

8 “(I) with respect to claims paid
9 electronically, the payment is trans-
10 ferred; and

11 “(II) with respect to claims paid
12 otherwise, the payment is submitted
13 to the United States Postal Service or
14 common carrier for delivery.

15 “(E) ELECTRONIC TRANSFER OF
16 FUNDS.—A PDP sponsor shall pay all clean
17 claims submitted electronically by electronic
18 transfer of funds if the pharmacy so requests or
19 has so requested previously. In the case where
20 such payment is made electronically, remittance
21 may be made by the PDP sponsor electronically
22 as well.

23 “(F) PROTECTING THE RIGHTS OF CLAIM-
24 ANTS.—

1 “(i) IN GENERAL.—Nothing in this
2 paragraph shall be construed to prohibit or
3 limit a claim or action not covered by the
4 subject matter of this section that any in-
5 dividual or organization has against a pro-
6 vider or a PDP sponsor.

7 “(ii) ANTI-RETALIATION.—Consistent
8 with applicable Federal or State law, a
9 PDP sponsor shall not retaliate against an
10 individual or provider for exercising a right
11 of action under this subparagraph.

12 “(G) RULE OF CONSTRUCTION.—A deter-
13 mination under this paragraph that a claim
14 submitted by a pharmacy is a clean claim shall
15 not be construed as a positive determination re-
16 garding eligibility for payment under this title,
17 nor is it an indication of government approval
18 of, or acquiescence regarding, the claim sub-
19 mitted. The determination shall not relieve any
20 party of civil or criminal liability with respect to
21 the claim, nor does it offer a defense to any ad-
22 ministrative, civil, or criminal action with re-
23 spect to the claim.”.

24 (b) PROMPT PAYMENT BY MA-PD PLANS.—Section
25 1857(f) of the Social Security Act (42 U.S.C. 1395w-27)

1 is amended by adding at the end the following new para-
 2 graph:

3 “(3) INCORPORATION OF CERTAIN PRESCRIP-
 4 TION DRUG PLAN CONTRACT REQUIREMENTS.—The
 5 following provisions shall apply to contracts with a
 6 Medicare Advantage organization offering an MA-
 7 PD plan in the same manner as they apply to con-
 8 tracts with a PDP sponsor offering a prescription
 9 drug plan under part D:

10 “(A) PROMPT PAYMENT.—Section 1860D-
 11 12(b)(4).”.

12 (c) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to plan years beginning on or after
 14 January 1, 2010.

15 **SEC. 172. SUBMISSION OF CLAIMS BY PHARMACIES LO-**
 16 **CATED IN OR CONTRACTING WITH LONG-**
 17 **TERM CARE FACILITIES.**

18 (a) SUBMISSION OF CLAIMS BY PHARMACIES LO-
 19 CATED IN OR CONTRACTING WITH LONG-TERM CARE FA-
 20 CILITIES.—

21 (1) SUBMISSION OF CLAIMS TO PRESCRIPTION
 22 DRUG PLANS.—Section 1860D-12(b) of the Social
 23 Security Act (42 U.S.C. 1395w-112(b)), as amend-
 24 ed by section 171(a), is amended by adding at the
 25 end the following new paragraph:

“(5) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that a pharmacy located in, or having a contract with, a long-term care facility shall have not less than 30 days (but not more than 90 days) to submit claims to the sponsor for reimbursement under the plan.”.

(2) SUBMISSION OF CLAIMS TO MA-PD PLANS.—Section 1857(f)(3) of the Social Security Act, as added by section 171(b), is amended by adding at the end the following new subparagraph:

“(B) SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.—Section 1860D–12(b)(5).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 2010.

SEC. 173. REGULAR UPDATE OF PRESCRIPTION DRUG PRICING STANDARD.

(a) REQUIREMENT FOR PRESCRIPTION DRUG PLANS.—Section 1860D–12(b) of the Social Security Act

1 (42 U.S.C. 1395w-112(b)), as amended by section
2 172(a)(1), is amended by adding at the end the following
3 new paragraph:

4 “(6) REGULAR UPDATE OF PRESCRIPTION
5 DRUG PRICING STANDARD.—If the PDP sponsor of
6 a prescription drug plan uses a standard for reim-
7 bursement of pharmacies based on the cost of a
8 drug, each contract entered into with such sponsor
9 under this part with respect to the plan shall provide
10 that the sponsor shall update such standard not less
11 frequently than once every 7 days, beginning with an
12 initial update on January 1 of each year, to accu-
13 rately reflect the market price of acquiring the
14 drug.”.

15 (b) REQUIREMENT FOR MA-PD PLANS.—Section
16 1857(f)(3) of the Social Security Act, as amended by sec-
17 tion 172(a)(2), is amended by adding at the end the fol-
18 lowing new subparagraph:

19 “(C) REGULAR UPDATE OF PRESCRIPTION
20 DRUG PRICING STANDARD.—Section 1860D-
21 12(b)(6).”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to plan years beginning on or after
24 January 1, 2009.

PART II—OTHER PROVISIONS

**SEC. 175. INCLUSION OF BARBITURATES AND
BENZODIAZEPINES AS COVERED PART D
DRUGS.**

(a) IN GENERAL.—Section 1860D–2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is amended by inserting after “agents),” the following “other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines),”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to prescriptions dispensed on or after January 1, 2012.

**SEC. 176. FORMULARY REQUIREMENTS WITH RESPECT TO
CERTAIN CATEGORIES OR CLASSES OF
DRUGS.**

Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended—

(1) in subparagraph (C)(i), by striking “The formulary” and inserting “Subject to subparagraph (G), the formulary”; and

(2) by inserting after subparagraph (F) the following new subparagraph:

1 “(G) REQUIRED INCLUSION OF DRUGS IN
2 CERTAIN CATEGORIES AND CLASSES.—

3 “(i) IDENTIFICATION OF DRUGS IN
4 CERTAIN CATEGORIES AND CLASSES.—Be-
5 ginning with plan year 2010, the Secretary
6 shall identify, as appropriate, categories
7 and classes of drugs for which both of the
8 following criteria are met:

9 “(I) Restricted access to drugs in
10 the category or class would have
11 major or life threatening clinical con-
12 sequences for individuals who have a
13 disease or disorder treated by the
14 drugs in such category or class.

15 “(II) There is significant clinical
16 need for such individuals to have ac-
17 cess to multiple drugs within a cat-
18 egory or class due to unique chemical
19 actions and pharmacological effects of
20 the drugs within the category or class,
21 such as drugs used in the treatment
22 of cancer.

23 “(ii) FORMULARY REQUIREMENTS.—
24 Subject to clause (iii), PDP sponsors offer-
25 ing prescription drug plans shall be re-

quired to include all covered part D drugs in the categories and classes identified by the Secretary under clause (i).

“(iii) EXCEPTIONS.—The Secretary may establish exceptions that permits a PDP sponsor of a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under clause (ii) (or to otherwise limit access to such a drug). Any exceptions established under the preceding sentence shall be provided under a process that—

“(I) ensures that any exception to such requirement is based upon scientific evidence and medical standards of practice; and

“(II) includes a public notice and comment period.”.

Subtitle F—Other Provisions

SEC. 181. USE OF PART D DATA.

Section 1860D–12(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–112(b)(3)(D)) is amended by adding at the end the following sentence: “Notwithstanding

1 any other provision of law, information provided to the
 2 Secretary under the application of section 1857(e)(1) to
 3 contracts under this section under the preceding sentence
 4 may be used for the purposes of carrying out this part,
 5 improving public health through research on the utiliza-
 6 tion, safety, effectiveness, quality, and efficiency of health
 7 care services (as the Secretary determines appropriate),
 8 and conducting Congressional oversight, monitoring, and
 9 analysis of the program under this title.”.

10 **SEC. 182. REVISION OF DEFINITION OF MEDICALLY AC-**
 11 **CEPTED INDICATION FOR DRUGS.**

12 (a) REVISION OF DEFINITION FOR PART D
 13 DRUGS.—

14 (1) IN GENERAL.—Section 1860D-2(e)(1) of
 15 the Social Security Act (42 U.S.C. 1395w-
 16 102(e)(1)) is amended, in the matter following sub-
 17 paragraph (B)—

18 (A) by striking “(as defined in section
 19 1927(k)(6))” and inserting “(as defined in
 20 paragraph (4))”; and

21 (B) by adding at the end the following new
 22 paragraph:

23 “(4) MEDICALLY ACCEPTED INDICATION DE-
 24 FINED.—

“(A) IN GENERAL.—For purposes of paragraph (1), the term ‘medically accepted indication’ has the meaning given that term—

“(i) in the case of a covered part D drug used in an anticancer chemotherapeutic regimen, in section 1861(t)(2)(B), except that in applying such section—

“(I) ‘prescription drug plan or MA–PD plan’ shall be substituted for ‘carrier’ each place it appears; and

“(II) subject to subparagraph (B), the compendia described in section 1927(g)(1)(B)(i)(III) shall be included in the list of compendia described in clause (ii)(I) section 1861(t)(2)(B); and

“(ii) in the case of any other covered part D drug, in section 1927(k)(6).

“(B) CONFLICT OF INTEREST.—On and after January 1, 2010, subparagraph (A)(i)(II) shall not apply unless the compendia described in section 1927(g)(1)(B)(i)(III) meets the requirement in the third sentence of section 1861(t)(2)(B).

1 “(C) UPDATE.—For purposes of applying
 2 subparagraph (A)(ii), the Secretary shall revise
 3 the list of compendia described in section
 4 1927(g)(1)(B)(i) as is appropriate for identi-
 5 fying medically accepted indications for drugs.
 6 Any such revision shall be done in a manner
 7 consistent with the process for revising com-
 8 pendia under section 1861(t)(2)(B).”.

9 (2) EFFECTIVE DATE.—The amendments made
 10 by this subsection shall apply to plan years begin-
 11 ning on or after January 1, 2009.

12 (b) CONFLICTS OF INTEREST.—Section
 13 1861(t)(2)(B) of the Social Security Act (42 U.S.C.
 14 1395x(t)(2)(B)) is amended by adding at the end the fol-
 15 lowing new sentence: “On and after January 1, 2010, no
 16 compendia may be included on the list of compendia under
 17 this subparagraph unless the compendia has a publicly
 18 transparent process for evaluating therapies and for iden-
 19 tifying potential conflicts of interests.”.

20 **SEC. 183. CONTRACT WITH A CONSENSUS-BASED ENTITY**
 21 **REGARDING PERFORMANCE MEASUREMENT.**

22 (a) CONTRACT.—

23 (1) IN GENERAL.—Part E of title XVIII of the
 24 Social Security Act (42 U.S.C. 1395x et seq.) is

1 amended by inserting after section 1889 the fol-
2 lowing new section:

3 “CONTRACT WITH A CONSENSUS-BASED ENTITY
4 REGARDING PERFORMANCE MEASUREMENT

5 “SEC. 1890. (a) CONTRACT.—

6 “(1) IN GENERAL.—For purposes of activities
7 conducted under this Act, the Secretary shall iden-
8 tify and have in effect a contract with a consensus-
9 based entity, such as the National Quality Forum,
10 that meets the requirements described in subsection
11 (c). Such contract shall provide that the entity will
12 perform the duties described in subsection (b).

13 “(2) TIMING FOR FIRST CONTRACT.—As soon
14 as practicable after the date of the enactment of this
15 subsection, the Secretary shall enter into the first
16 contract under paragraph (1).

17 “(3) PERIOD OF CONTRACT.—A contract under
18 paragraph (1) shall be for a period of 4 years (ex-
19 cept as may be renewed after a subsequent bidding
20 process).

21 “(4) COMPETITIVE PROCEDURES.—Competitive
22 procedures (as defined in section 4(5) of the Office
23 of Federal Procurement Policy Act (41 U.S.C.
24 403(5))) shall be used to enter into a contract under
25 paragraph (1).

1 “(b) DUTIES.—The duties described in this sub-
2 section are the following:

3 “(1) PRIORITY SETTING PROCESS.—The entity
4 shall synthesize evidence and convene key stake-
5 holders to make recommendations, with respect to
6 activities conducted under this Act, on an integrated
7 national strategy and priorities for health care per-
8 formance measurement in all applicable settings. In
9 making such recommendations, the entity shall—

10 “(A) ensure that priority is given to meas-
11 ures—

12 “(i) that address the health care pro-
13 vided to patients with prevalent, high-cost
14 chronic diseases;

15 “(ii) with the greatest potential for
16 improving the quality, efficiency, and pa-
17 tient-centeredness of health care; and

18 “(iii) that may be implemented rap-
19 idly due to existing evidence, standards of
20 care, or other reasons; and

21 “(B) take into account measures that—

22 “(i) may assist consumers and pa-
23 tients in making informed health care deci-
24 sions;

“(ii) address health disparities across groups and areas; and

“(iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

“(2) ENDORSEMENT OF MEASURES.—The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

“(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and

“(B) is consistent across types of health care providers, including hospitals and physicians.

“(3) MAINTENANCE OF MEASURES.—The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are up-

1 dated (or retired if obsolete) as new evidence is de-
2 veloped.

3 “(4) PROMOTION OF THE DEVELOPMENT OF
4 ELECTRONIC HEALTH RECORDS.—The entity shall
5 promote the development and use of electronic
6 health records that contain the functionality for
7 automated collection, aggregation, and transmission
8 of performance measurement information.

9 “(5) ANNUAL REPORT TO CONGRESS AND THE
10 SECRETARY; SECRETARIAL PUBLICATION AND COM-
11 MENT.—

12 “(A) ANNUAL REPORT.—By not later than
13 March 1 of each year (beginning with 2009),
14 the entity shall submit to Congress and the Sec-
15 retary a report containing a description of—

16 “(i) the implementation of quality
17 measurement initiatives under this Act and
18 the coordination of such initiatives with
19 quality initiatives implemented by other
20 payers;

21 “(ii) the recommendations made
22 under paragraph (1); and

23 “(iii) the performance by the entity of
24 the duties required under the contract en-

1 tered into with the Secretary under sub-
2 section (a).

3 “(B) SECRETARIAL REVIEW AND PUBLICA-
4 TION OF ANNUAL REPORT.—Not later than 6
5 months after receiving a report under subpara-
6 graph (A) for a year, the Secretary shall—

7 “(i) review such report; and

8 “(ii) publish such report in the Fed-
9 eral Register, together with any comments
10 of the Secretary on such report.

11 “(c) REQUIREMENTS DESCRIBED.—The require-
12 ments described in this subsection are the following:

13 “(1) PRIVATE NONPROFIT.—The entity is a pri-
14 vate nonprofit entity governed by a board.

15 “(2) BOARD MEMBERSHIP.—The members of
16 the board of the entity include—

17 “(A) representatives of health plans and
18 health care providers and practitioners or rep-
19 resentatives of groups representing such health
20 plans and health care providers and practi-
21 tioners;

22 “(B) health care consumers or representa-
23 tives of groups representing health care con-
24 sumers; and

1 “(C) representatives of purchasers and em-
2 ployers or representatives of groups rep-
3 resenting purchasers or employers.

4 “(3) ENTITY MEMBERSHIP.—The membership
5 of the entity includes persons who have experience
6 with—

7 “(A) urban health care issues;

8 “(B) safety net health care issues;

9 “(C) rural and frontier health care issues;

10 and

11 “(D) health care quality and safety issues.

12 “(4) OPEN AND TRANSPARENT.—With respect
13 to matters related to the contract with the Secretary
14 under subsection (a), the entity conducts its business
15 in an open and transparent manner and provides the
16 opportunity for public comment on its activities.

17 “(5) VOLUNTARY CONSENSUS STANDARDS SET-
18 TING ORGANIZATION.—The entity operates as a vol-
19 untary consensus standards setting organization as
20 defined for purposes of section 12(d) of the National
21 Technology Transfer and Advancement Act of 1995
22 (Public Law 104–113) and Office of Management
23 and Budget Revised Circular A–119 (published in
24 the Federal Register on February 10, 1998).

1 “(6) EXPERIENCE.—The entity has at least 4
2 years of experience in establishing national con-
3 sensus standards.

4 “(7) MEMBERSHIP FEES.—If the entity re-
5 quires a membership fee for participation in the
6 functions of the entity, such fees shall be reasonable
7 and adjusted based on the capacity of the potential
8 member to pay the fee. In no case shall membership
9 fees pose a barrier to the participation of individuals
10 or groups with low or nominal resources to partici-
11 pate in the functions of the entity.

12 “(d) FUNDING.—For purposes of carrying out this
13 section, the Secretary shall provide for the transfer, from
14 the Federal Hospital Insurance Trust Fund under section
15 1817 and the Federal Supplementary Medical Insurance
16 Trust Fund under section 1841 (in such proportion as the
17 Secretary determines appropriate), of \$10,000,000 to the
18 Centers for Medicare & Medicaid Services Program Man-
19 agement Account for each of fiscal years 2009 through
20 2012.”.

21 (2) SENSE OF THE SENATE.—It is the Sense of
22 the Senate that the selection by the Secretary of
23 Health and Human Services of an entity to contract
24 with under section 1890(a) of the Social Security
25 Act, as added by paragraph (1), should not be con-

1 strued as diminishing the significant contributions of
2 the Boards of Medicine, the quality alliances, and
3 other clinical and technical experts to efforts to
4 measure and improve the quality of health care serv-
5 ices.

6 (b) GAO STUDY AND REPORTS ON THE PERFORM-
7 ANCE AND COSTS OF THE CONSENSUS-BASED ENTITY
8 UNDER THE CONTRACT.—

9 (1) IN GENERAL.—The Comptroller General of
10 the United States shall conduct a study on—

11 (A) the performance of the entity with a
12 contract with the Secretary of Health and
13 Human Services under section 1890(a) of the
14 Social Security Act, as added by subsection (a),
15 of its duties under such contract; and

16 (B) the costs incurred by such entity in
17 performing such duties.

18 (2) REPORTS.—Not later than 18 months and
19 36 months after the effective date of the first con-
20 tract entered into under such section 1890(a), the
21 Comptroller General of the United States shall sub-
22 mit to Congress a report containing the results of
23 the study conducted under paragraph (1), together
24 with recommendations for such legislation and ad-

1 administrative action as the Comptroller General deter-
2 mines appropriate.

3 **SEC. 184. COST-SHARING FOR CLINICAL TRIALS.**

4 Section 1833 of the Social Security Act (42 U.S.C.
5 1395l), as amended by section 152(a), is amended by add-
6 ing at the end the following new subsection:

7 “(x) METHODS OF PAYMENT.—The Secretary may
8 develop alternative methods of payment for items and
9 services provided under clinical trials and comparative ef-
10 fectiveness studies sponsored or supported by an agency
11 of the Department of Health and Human Services, as de-
12 termined by the Secretary, to those that would otherwise
13 apply under this section, to the extent such alternative
14 methods are necessary to preserve the scientific validity
15 of such trials or studies, such as in the case where mask-
16 ing the identity of interventions from patients and inves-
17 tigators is necessary to comply with the particular trial
18 or study design.”.

19 **SEC. 185. ADDRESSING HEALTH CARE DISPARITIES.**

20 Title XVIII of the Social Security Act (42 U.S.C.
21 1395 et seq.) is amended by inserting after section 1808
22 the following new section:

23 “ADDRESSING HEALTH CARE DISPARITIES

24 “SEC. 1809. (a) EVALUATING DATA COLLECTION
25 APPROACHES.—The Secretary shall evaluate approaches
26 for the collection of data under this title, to be performed

1 in conjunction with existing quality reporting require-
2 ments and programs under this title, that allow for the
3 ongoing, accurate, and timely collection and evaluation of
4 data on disparities in health care services and performance
5 on the basis of race, ethnicity, and gender. In conducting
6 such evaluation, the Secretary shall consider the following
7 objectives:

8 “(1) Protecting patient privacy.

9 “(2) Minimizing the administrative burdens of
10 data collection and reporting on providers and health
11 plans participating under this title.

12 “(3) Improving Medicare program data on race,
13 ethnicity, and gender.

14 “(b) REPORTS TO CONGRESS.—

15 “(1) REPORT ON EVALUATION.—Not later than
16 18 months after the date of the enactment of this
17 section, the Secretary shall submit to Congress a re-
18 port on the evaluation conducted under subsection
19 (a). Such report shall, taking into consideration the
20 results of such evaluation—

21 “(A) identify approaches (including defin-
22 ing methodologies) for identifying and collecting
23 and evaluating data on health care disparities
24 on the basis of race, ethnicity, and gender for
25 the original Medicare fee-for-service program

1 under parts A and B, the Medicare Advantage
2 program under part C, and the Medicare pre-
3 scription drug program under part D; and

4 “(B) include recommendations on the most
5 effective strategies and approaches to reporting
6 HEDIS quality measures as required under sec-
7 tion 1852(e)(3) and other nationally recognized
8 quality performance measures, as appropriate,
9 on the basis of race, ethnicity, and gender.

10 “(2) REPORTS ON DATA ANALYSES.—Not later
11 than 4 years after the date of the enactment of this
12 section, and 4 years thereafter, the Secretary shall
13 submit to Congress a report that includes rec-
14 ommendations for improving the identification of
15 health care disparities for Medicare beneficiaries
16 based on analyses of the data collected under sub-
17 section (c).

18 “(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
19 later than 24 months after the date of the enactment of
20 this section, the Secretary shall implement the approaches
21 identified in the report submitted under subsection (b)(1)
22 for the ongoing, accurate, and timely collection and eval-
23 uation of data on health care disparities on the basis of
24 race, ethnicity, and gender.”.

1 **SEC. 186. DEMONSTRATION TO IMPROVE CARE TO PRE-**
2 **VIOUSLY UNINSURED.**

3 (a) **ESTABLISHMENT.**—Within one year after the
4 date of the enactment of this Act, the Secretary (in this
5 section referred to as the “Secretary”) shall establish a
6 demonstration project to determine the greatest needs and
7 most effective methods of outreach to medicare bene-
8 ficiaries who were previously uninsured.

9 (b) **SCOPE.**—The demonstration shall be in no fewer
10 than 10 sites, and shall include state health insurance as-
11 sistance programs, community health centers, community-
12 based organizations, community health workers, and other
13 service providers under parts A, B, and C of title XVIII
14 of the Social Security Act. Grantees that are plans oper-
15 ating under part C shall document that enrollees who were
16 previously uninsured receive the “Welcome to Medicare”
17 physical exam.

18 (c) **DURATION.**—The Secretary shall conduct the
19 demonstration project for a period of 2 years.

20 (d) **REPORT AND EVALUATION.**—The Secretary shall
21 conduct an evaluation of the demonstration and not later
22 than 1 year after the completion of the project shall sub-
23 mit to Congress a report including the following:

24 (1) An analysis of the effectiveness of outreach
25 activities targeting beneficiaries who were previously
26 uninsured, such as revising outreach and enrollment

materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

**SEC. 187. OFFICE OF THE INSPECTOR GENERAL REPORT
ON COMPLIANCE WITH AND ENFORCEMENT
OF NATIONAL STANDARDS ON CULTURALLY
AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.**

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

1 (2) a description of the costs associated with or
 2 savings related to the provision of language services.
 3 Such report shall include recommendations on improving
 4 compliance with CLAS Standards and recommendations
 5 on improving enforcement of CLAS Standards.

6 (b) IMPLEMENTATION.—Not later than one year
 7 after the date of publication of the report under subsection
 8 (a), the Department of Health and Human Services shall
 9 implement changes responsive to any deficiencies identi-
 10 fied in the report.

11 **SEC. 188. MEDICARE IMPROVEMENT FUNDING.**

12 (a) MEDICARE IMPROVEMENT FUND.—Title XVIII
 13 of the Social Security Act (42 U.S.C. 1395 et seq.) is
 14 amended by adding at the end the following new section:

15 “MEDICARE IMPROVEMENT FUND

16 “SEC. 1898. (a) ESTABLISHMENT.—

17 “The Secretary shall establish under this title a
 18 Medicare Improvement Fund (in this section re-
 19 ferred to as the ‘Fund’) which shall be available to
 20 the Secretary to make improvements under the origi-
 21 nal fee-for-service program under parts A and B for
 22 individuals entitled to, or enrolled for, benefits under
 23 part A or enrolled under part B.

24 “(b) FUNDING.—

25 “(1) IN GENERAL.—There shall be available to
 26 the Fund, for expenditures from the Fund for serv-

1 ices furnished during fiscal years 2013–2017,
2 \$22,450,000,000.

3 “(2) PAYMENT FROM TRUST FUNDS.—The
4 amount specified under paragraph (1) shall be avail-
5 able to the Fund, as expenditures are made from the
6 Fund, from the Federal Hospital Insurance Trust
7 Fund and the Federal Supplementary Medical In-
8 surance Trust Fund in such proportion as the Sec-
9 retary determines appropriate.

10 “(3) FUNDING LIMITATION.—Amounts in the
11 Fund shall be available in advance of appropriations
12 but only if the total amount obligated from the
13 Fund does not exceed the amount available to the
14 Fund under paragraph (1). The Secretary may obli-
15 gate funds from the Fund only if the Secretary de-
16 termines (and the Chief Actuary of the Centers for
17 Medicare & Medicaid Services and the appropriate
18 budget officer certify) that there are available in the
19 Fund sufficient amounts to cover all such obligations
20 incurred consistent with the previous sentence.”.

21 (b) IMPLEMENTATION.—For purposes of carrying out
22 the provisions of, and amendments made by, this Act, in
23 addition to any other amounts provided in such provisions
24 and amendments, the Secretary of Health and Human
25 Services shall provide for the transfer, from the Federal

1 Hospital Insurance Trust Fund under section 1817 of the
 2 Social Security Act (42 U.S.C. 1395i) and the Federal
 3 Supplementary Medical Insurance Trust Fund under sec-
 4 tion 1841 of such Act (42 U.S.C. 1395t), in the same pro-
 5 portion as the Secretary determines under section 1853(f)
 6 of such Act (42 U.S.C. 1395w-23(f)), of \$140,000,000
 7 to the Centers for Medicare & Medicaid Services Program
 8 Management Account for the period of fiscal years 2009
 9 through 2013.

10 **TITLE II—MEDICAID**

11 **SEC. 201. EXTENSION OF TRANSITIONAL MEDICAL ASSIST-** 12 **ANCE (TMA).**

13 Section 401 of division B of the Tax Relief and
 14 Health Care Act of 2006 (Public Law 109-432, 120 Stat.
 15 2994), as amended by section 1 of Public Law 110-48
 16 (121 Stat. 244), section 2 of the TMA, Abstinence, Edu-
 17 cation, and QI Programs Extension Act of 2007 (Public
 18 Law 110-90, 121 Stat. 984), and section 202 of the Medi-
 19 care, Medicaid, and SCHIP Extension Act of 2007 (Public
 20 Law 110-173) is amended—

21 (1) by inserting after “June 30, 2008” the fol-
 22 lowing “(or, in the case of section 1925, through De-
 23 cember 31, 2009)”;

24 (2) by inserting after “the third quarter of fis-
 25 cal year 2008” the following: “(or, in the case of

such section 1925, the first quarter of fiscal year 2010)”; and

(3) by inserting after “the third quarter of fiscal year 2007” the following: “(or, in the case of such section 1925, the first quarter of fiscal year 2008)”.

SEC. 202. MEDICAID DSH EXTENSION.

Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r-4(f)(6)) is amended—

(1) in the heading, by striking “FISCAL YEAR 2007 AND PORTIONS OF FISCAL YEAR 2008” and inserting “FISCAL YEARS 2007 THROUGH 2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010”; and

(2) in subparagraph (A)—

(A) in clause (i)—

(i) in the second sentence—

(I) by striking “fiscal year 2008 for the period ending on June 30, 2008” and inserting “fiscal years 2008 and 2009”; and

(II) by striking “ $\frac{3}{4}$ of”; and

(ii) by adding at the end the following new sentences: “Only with respect to fiscal year 2010 for the period ending on Decem-

1 ber 31, 2009, the DSH allotment for Ten-
2 nessee for such portion of the fiscal year,
3 notwithstanding such table or terms, shall
4 be $\frac{1}{4}$ of the amount specified in the first
5 sentence for fiscal year 2007.”;

6 (B) in clause (ii), by striking “or for a pe-
7 riod in fiscal year 2008” and inserting “, 2008,
8 2009, or for a period in fiscal year 2010”;

9 (C) in clause (iv)—

10 (i) in the heading, by striking “FISCAL
11 YEAR 2007 AND FISCAL YEAR 2008” and in-
12 serting “FISCAL YEARS 2007 THROUGH 2009
13 AND THE FIRST CALENDAR QUARTER OF
14 FISCAL YEAR 2010”;

15 (ii) in subclause (I), by striking “or
16 for a period in fiscal year 2008” and in-
17 serting “, 2008, 2009, or for a period in
18 fiscal year 2010”; and

19 (iii) in subclause (II), by striking “or
20 for a period in fiscal year 2008” and in-
21 serting “, 2008, 2009, or for a period in
22 fiscal year 2010”; and

23 (3) in subparagraph (B)(i)—

(A) in the first sentence, by striking “fiscal year 2007” and inserting “each of fiscal years 2007 through 2009”; and

(B) by striking the second sentence and inserting the following: “Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$2,500,000.”.

SEC. 203. PHARMACY REIMBURSEMENT UNDER MEDICAID.

(a) DELAY IN NEW PAYMENT LIMITS FOR MULTIPLE SOURCE DRUGS UNDER MEDICAID.—Notwithstanding paragraphs (4) and (5) of subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) or part 447 of title 42, Code of Federal Regulations (as in effect on the date of the enactment of this Act), the Secretary of Health and Human Services shall not require a State to establish prior to September 30, 2009, payment limits for multiple source drugs under a State Medicaid plan that do not exceed the specific upper limit established under section 447.514(b) of title 42, Code of Federal Regulations (as so in effect) and shall permit any State to continue to receive Federal financial participation for payments for such drugs that do not exceed the specific upper

1 limit that would have applied to such payments under sec-
2 tion 447.332 of title 42, Code of Federal Regulations (as
3 in effect on December 31, 2006).

4 (b) TEMPORARY SUSPENSION OF UPDATED PUB-
5 LICLY AVAILABLE AMP DATA.—Notwithstanding clause
6 (v) of section 1927(b)(3)(D) of the Social Security Act (42
7 U.S.C. 1396r–8(b)(3)(D)), the Secretary of Health and
8 Human Services shall not, prior to September 30, 2009,
9 make publicly available any AMP disclosed to the Sec-
10 retary.

11 (c) DEFINITIONS.—In this subsection:

12 (1) The term “multiple source drug” has the
13 meaning given that term in section 1927(k)(7)(A)(i)
14 of the Social Security Act (42 U.S.C. 1396r–
15 8(k)(7)(A)(i)); and

16 (2) The term “AMP” has the meaning given
17 “average manufacturer price” in section 1927(k)(1)
18 of the Social Security Act (42 U.S.C. 1396r–
19 8(k)(1)) and “AMP” in section 447.504(a) of title
20 42, Code of Federal Regulations (as in effect on the
21 date of the enactment of this Act).

1 **SEC. 204. REVIEW OF ADMINISTRATIVE CLAIM DETERMINA-**
2 **TIONS.**

3 (a) IN GENERAL.—Section 1116 of the Social Secu-
4 rity Act (42 U.S.C. 1316) is amended by adding at the
5 end the following new subsection:

6 “(e)(1) Whenever the Secretary determines that any
7 item or class of items on account of which Federal finan-
8 cial participation is claimed under title XIX shall be dis-
9 allowed for such participation, the State shall be entitled
10 to and upon request shall receive a reconsideration of the
11 disallowance, provided that such request is made during
12 the 60-day period that begins on the date the State re-
13 ceives notice of the disallowance.

14 “(2)(A) A State may appeal a disallowance of a claim
15 for federal financial participation under title XIX by the
16 Secretary, or an unfavorable reconsideration of a disallow-
17 ance, during the 60-day period that begins on the date
18 the State receives notice of the disallowance or of the unfa-
19 vorable reconsideration, in whole or in part, to the Depart-
20 mental Appeals Board, established in the Department of
21 Health and Human Services (in this paragraph referred
22 to as the ‘Board’), by filing a notice of appeal with the
23 Board.

24 “(B) The Board shall consider a State’s appeal of
25 a disallowance of such a claim (or of an unfavorable recon-
26 sideration of a disallowance) on the basis of such docu-

1 mentation as the State may submit and as the Board may
2 require to support the final decision of the Board. In de-
3 ciding whether to uphold a disallowance of such a claim
4 or any portion thereof, the Board shall be bound by all
5 applicable laws and regulations and shall conduct a thor-
6 ough review of the issues, taking into account all relevant
7 evidence. The Board's decision of an appeal under sub-
8 paragraph (A) shall be the final decision of the Secretary
9 and shall be subject to reconsideration by the Board only
10 upon motion of either party filed during the 60-day period
11 that begins on the date of the Board's decision or to judi-
12 cial review in accordance with subparagraph (C).

13 “(C) A State may obtain judicial review of a decision
14 of the Board by filing an action in any United States Dis-
15 trict Court located within the appealing State (or, if sev-
16 eral States jointly appeal the disallowance of claims for
17 Federal financial participation under section 1903, in any
18 United States District Court that is located within any
19 State that is a party to the appeal) or the United States
20 District Court for the District of Columbia. Such an ac-
21 tion may only be filed—

22 “(i) if no motion for reconsideration was filed
23 within the 60-day period specified in subparagraph
24 (B), during such 60-day period; or

“(ii) if such a motion was filed within such period, during the 60-day period that begins on the date of the Board’s decision on such motion.”.

(b) CONFORMING AMENDMENT.—Section 1116(d) of such Act (42 U.S.C. 1316(d)) is amended by striking “or XIX,”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and apply to any disallowance of a claim for Federal financial participation under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) made on or after such date or during the 60-day period prior to such date.

TITLE III—MISCELLANEOUS

SEC. 301. EXTENSION OF TANF SUPPLEMENTAL GRANTS.

(a) EXTENSION THROUGH FISCAL YEAR 2009.—Section 7101(a) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 135) is amended by striking “fiscal year 2008” and inserting “fiscal year 2009”.

(b) CONFORMING AMENDMENT.—Section 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C. 603(a)(3)(H)(ii)) is amended to read as follows:

“(ii) subparagraph (G) shall be applied as if ‘fiscal year 2009’ were substituted for ‘fiscal year 2001’; and”.

1 **SEC. 302. 70 PERCENT FEDERAL MATCHING FOR FOSTER**
2 **CARE AND ADOPTION ASSISTANCE FOR THE**
3 **DISTRICT OF COLUMBIA.**

4 (a) **IN GENERAL.**—Section 474(a) of the Social Secu-
5 rity Act (42 U.S.C. 674(a)) is amended in each of para-
6 graphs (1) and (2) by striking “(as defined in section
7 1905(b) of this Act)” and inserting “(which shall be as
8 defined in section 1905(b), in the case of a State other
9 than the District of Columbia, or 70 percent, in the case
10 of the District of Columbia)”.

11 (b) **EFFECTIVE DATE.**—The amendment made by
12 subsection (a) shall take effect on October 1, 2008, and
13 shall apply to calendar quarters beginning on or after that
14 date.

15 **SEC. 303. EXTENSION OF SPECIAL DIABETES GRANT PRO-**
16 **GRAMS.**

17 (a) **SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-**
18 **BETES.**—Section 330B(b)(2)(C) of the Public Health
19 Service Act (42 U.S.C. 254c–2(b)(2)) is amended by strik-
20 ing “2009” and inserting “2011”.

21 (b) **SPECIAL DIABETES PROGRAMS FOR INDIANS.**—
22 Section 330C(c)(2)(C) of the Public Health Service Act
23 (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking
24 “2009” and inserting “2011”.

25 (c) **REPORT ON GRANT PROGRAMS.**—Section 4923(b)
26 of the Balanced Budget Act of 1997 (42 U.S.C. 1254c–

1 2 note), as amended by section 931(c) of the Medicare,
2 Medicaid, and SCHIP Benefits Improvement and Protec-
3 tion Act of 2000, as enacted into law by section 1(a)(6)
4 of Public Law 106-554, and section 1(c) of Public Law
5 107-360, is amended—

6 (1) in paragraph (1), by striking “and” at the
7 end;

8 (2) in paragraph (2)—

9 (A) by striking “a final report” and insert-
10 ing “a second interim report”; and

11 (B) by striking the period at the end and
12 inserting “; and”; and

13 (3) by adding at the end the following new
14 paragraph:

15 “(3) a report on such evaluation not later than
16 January 1, 2011.”.

17 **SEC. 304. IOM REPORTS ON BEST PRACTICES FOR CON-**
18 **DUCTING SYSTEMATIC REVIEWS OF CLIN-**
19 **ICAL EFFECTIVENESS RESEARCH AND FOR**
20 **DEVELOPING CLINICAL PROTOCOLS.**

21 (a) **SYSTEMATIC REVIEWS OF CLINICAL EFFECTIVE-**
22 **NESS RESEARCH.—**

23 (1) **STUDY.**—Not later than 60 days after the
24 date of the enactment of this Act, the Secretary of
25 Health and Human Services shall enter into a con-

1 tract with the Institute of Medicine of the National
2 Academies (in this section referred to as the “Insti-
3 tute”) under which the Institute shall conduct a
4 study to identify the methodological standards for
5 conducting systematic reviews of clinical effective-
6 ness research on health and health care in order to
7 ensure that organizations conducting such reviews
8 have information on methods that are objective, sci-
9 entifically valid, and consistent.

10 (2) REPORT.—Not later than 18 months after
11 the effective date of the contract under paragraph
12 (1), the Institute, as part of such contract, shall
13 submit to the Secretary of Health and Human Serv-
14 ices and the appropriate committees of jurisdiction
15 of Congress a report containing the results of the
16 study conducted under paragraph (1), together with
17 recommendations for such legislation and adminis-
18 trative action as the Institute determines appro-
19 priate.

20 (3) PARTICIPATION.—The contract under para-
21 graph (1) shall require that stakeholders with exper-
22 tise in conducting clinical effectiveness research par-
23 ticipate on the panel responsible for conducting the
24 study under paragraph (1) and preparing the report
25 under paragraph (2).

1 (b) CLINICAL PROTOCOLS.—

2 (1) STUDY.—Not later than 60 days after the
3 date of the enactment of this Act, the Secretary of
4 Health and Human Services shall enter into a con-
5 tract with the Institute of Medicine of the National
6 Academies (in this section referred to as the “Insti-
7 tute”) under which the Institute shall conduct a
8 study on the best methods used in developing clinical
9 practice guidelines in order to ensure that organiza-
10 tions developing such guidelines have information on
11 approaches that are objective, scientifically valid,
12 and consistent.

13 (2) REPORT.—Not later than 18 months after
14 the effective date of the contract under paragraph
15 (1), the Institute, as part of such contract, shall
16 submit to the Secretary of Health and Human Serv-
17 ices and the appropriate committees of jurisdiction
18 of Congress a report containing the results of the
19 study conducted under paragraph (1), together with
20 recommendations for such legislation and adminis-
21 trative action as the Institute determines appro-
22 priate.

23 (3) PARTICIPATION.—The contract under para-
24 graph (1) shall require that stakeholders with exper-
25 tise in making clinical recommendations participate

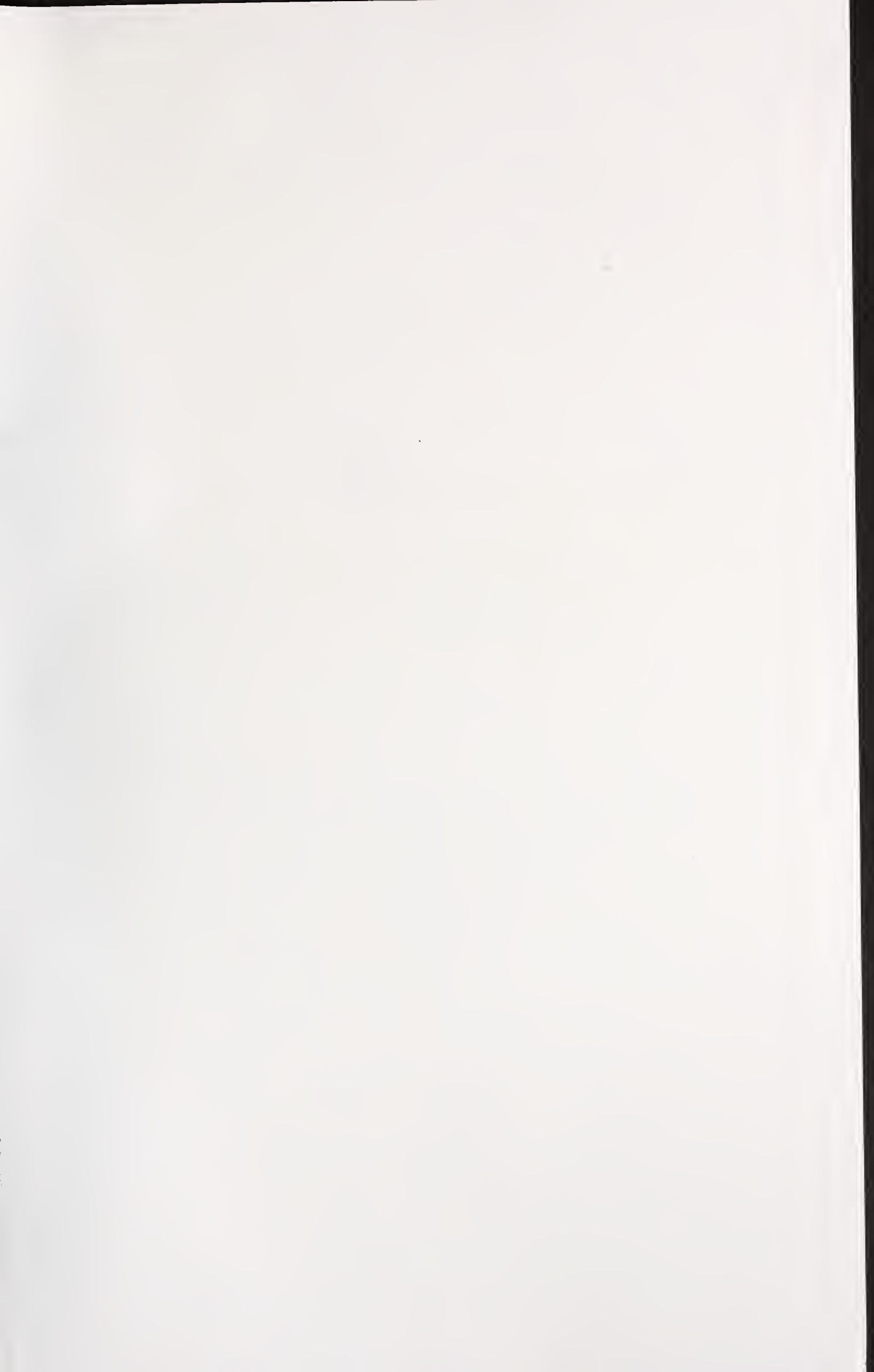
1 on the panel responsible for conducting the study
2 under paragraph (1) and preparing the report under
3 paragraph (2).

4 (c) FUNDING.—Out of any funds in the Treasury not
5 otherwise appropriated, there are appropriated for the pe-
6 riod of fiscal years 2009 and 2010, \$3,000,000 to carry
7 out this section.

8 **SEC. 305. INCREASING NUMBER OF PRIMARY CARE PHYSI-**
9 **CIA NS.**

10 Not later than one year after the date of the enact-
11 ment of this Act, the Secretary of Health and Human
12 Services, in coordination with the Association of American
13 Medical Colleges, shall submit to Congress an effective
14 plan to increase the number of primary care physicians,
15 particularly those practicing in counties, cities, or towns
16 classified as underserved or with a disproportionate num-
17 ber of Medicare beneficiaries.

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